DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
BOX 788250
MARINE CORPS AIR GROUND COMBAT CENTER
TWENTYNINE PALMS, CALIFORNIA 92278-8250

IN REPLY REFER TO:
NAVHOSP29PALMSINST 6300.1
Code 0105
21 March 1994

NAVAL HOSPITAL TWENTYNINE PALMS INSTRUCTION 6300.1

From: Commanding Officer

Subj: PATIENT ADMINISTRATION

Ref: (a) AMH (JCAHO) 1994
(b) NAVMEDCOMINST 6150.1
(c) NAVHOSP29PALMS 6320.5A
(d) NAVMEDCOMINST 6320.3B
(e) NAVHOSP29PALMS 6320.71
(f) MILPERSMAN
(g) OPNAVINST 6000.1
(h) MCO 5000.12C
(i) NAVMEDCOMINST 6220.2
(j) Manual of the Medical Department (MANMED)
(k) California Civil Code
(l) SECNAVINST 6300.2A
(m) BUMEDINST 6320.57
(n) SECNAVINST 6300.4
(o) California Hospital Association L-113
(p) BUMEDNOTE 6100 OF 3 Dec 91
(q) NAVMEDCOMINST 6320.18
(r) NAVHOSP29PALMSINST 7030.1A
(s) NAVMEDCOMINST 6320.9A
(t) BUMEDINST 6010.4
(u) MILPERSMAN
(v) NAVMEDCOMINST 5360.1
(w) California Health and Safety Codes, Section 10250
(x) NAVHOSP29PALMSINST 1752.1A
(y) SECNAVINST 1850.4C
(z) BUMEDINST 6320.1E

Encl: (1) Naval Hospital, Twentynine Palms Patient Administration Manual

1. Cancellation. BRHOSPINST 5360.1C, NAVHOSP29PALMSINST 5890.1, NAVHOSP29PALMSINST 6010.5B, NAVHOSP29PALMSINST 6320.8B, NAVHOSP29PALMSINST 6320.67, NAVHOSP29PALMSINST 6320.3 NAVHOSP29PALMSINST 6320.72A, NAVHOSP29PALMSINST 1730.1, NAVHOSP29PALMSINST 6320.70A, NAVHOSP29PALMSINST 6320.13, NAVHOSP29PALMSINST 6300.2, NAVHOSP29PALMSINST 6010.2A, NAVHOSP29PALMSINST 6320.4, NAVHOSP29PALMSINST 6460.3, NAVHOSP29PALMSINST 6320.7, and BRHOSPINST 6320.1E.

2. Purpose. To provide guidance relative to the overall objectives and policies of patient administrative functions in accordance with references (a) through (z). Enclosure (1) is provided as an administrative tool to assist staff members in ensuring the requirements of higher directives are met.

3. Applicability. This instruction is applicable for all personnel aboard Naval Hospital, Twentynine Palms, California.

4. New or Revised Forms

a. NH29PALMS 6010/30, Pre-op Teaching Sheet; NH29PALMS 6150/21, Record Discrepancy; NH29PALMS 6150/31, Transition Newborn Summary; NH29PALMS 6150/32, 24-Hour Nursery Flow Sheet; NH29PALMS 6150/33, Newborn Maturity Rating and Classification; NH29PALMS 6150/35, Inpatient Checkout Guide; NAVHOSP29PALMS Form 6300/01, Patient Memo for Failure to Show for Appointment; NAVHOSP29PALMS Form 6300/02, Sponsor Memo for Dependent Failure to Show for Appointment; NH29PALMS 6300/4, Labor Room Flow Sheet; NH29PALMS 6320/5, Medical Revised duty Status; NH29PALMS 6320/07, Request for Elective Surgery; NH29PALMS 6320/21A, Inpatient Clinical Chart Checkoff List; NH29PALMS 6320/70, Report of Inpatient Dispositions; NH29PALMS 6320/71, Statement of Refusal of Treatment Against Medical Advice; NH29PALMS 6550/10, IV Flow Sheet; and NH29PALMS 10460/03, Patient Transfer Form are being adopted in accordance with this instruction and may be obtained through Central Files.

b. SF-502, Narrative Summary; SF-533, Prenatal and Pregnancy; SF-522, Operations/Procedures Consent; NAVMED 6150/5, Abbreviated TLD; NAVMED 6320/30, Disengagement Form; DD-2161, Referral for Civilian Care; SF-539, Abbreviated Medical Record; SF-509, Progress Notes; SF-600, Chronological Record of Medical Care; NAVPERS 1336/3, Special Request; DD-2005, Privacy Act Statement; NAVMED 6150/8, Outpatient Records Release Request; DD-877, Request for Medical/Dental Records; SF-558, Emergency Care and Treatment Record; NAVMED 6010/9, Patient Valuable Envelope; NAVMED 6320/5, Serious or Very Serious Condition or Death of Patient; NAVMED 6300/5; SF-523, Autopsy Authorization; SF-88, Medical Exam; SF-513, Consultation; DD-602, Medevac Tag; SF-504, SF-505 and SF-506 History Parts 1, 2, 3 and Physical Exam; SF-508, Doctors Orders; SF-510, Nursing Notes; SF-515, Tissue Examination; SF-516, Operation Report; SF-517, Anesthesia; SF-518, Blood or Blood Component Transfusions; SF-519, Radiology Reports; SF-519A, Backing Sheet for Mounting Radiology Reports; SF-545, Lab Display Sheet; SF-546-557, Laboratory Reports; NAVMED 6320/11, Newborn Identification Sheet; NAVMED 6320/16, Recovery Room Record; NAVMED 6320/8, Medication Identification Record; NAVMED 6550/14, Patient Data Base; NAVMED 6550/12, Patient Profile; NAVMED 6550/13, Patient Care Plan; SF-520, EKG Record; and SF-535, Newborn Clinical Record may be obtained through Central Files.

/s/
M. J. ROMAN
Acting

Distribution:
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DEPARTMENT OF THE NAVY
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TWENTYNINE PALMS, CALIFORNIA 92278-8250

IN REPLY REFER TO:

NAVHOSP29PALMSINST 6300.1 CH-1
Code 0105
7 Jul 1995

NAVAL HOSPITAL TWENTYNINE PALMS INSTRUCTION 6300.1 CHANGE TRANSMITTAL 1

From: Commanding Officer

Subj: **PATIENT ADMINISTRATION**

Encl: (1) Revised Appendix C

1. **Purpose**. To transmit new page insert to the basic instruction.

2. **Action**. Remove page 1 of Appendix C of the basic instruction and insert enclosure (1). As of this date only the new revision of this statement of refusal of treatment against medical advice will be utilized. All previous revision will be destroyed.

C. S. CHITWOOD

DEPARTMENT OF THE NAVY
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IN REPLY REFER TO:
NAVHOSP29PALMSINST 6300.1 CH-2
Code 0105
7 November 1996

NAVAL HOSPITAL TWENTYNINE PALMS INSTRUCTION 6300.2 CHANGE TRANSMITTAL 2

From: Commanding Officer

Subj: **PATIENT ADMINISTRATION**

1. **Purpose**. To direct pen and ink changes to the basic instruction.

2. **Action**. On page 67, Chapter 13, paragraph 13-2 subparagraph 2 (1) delete in entirety and insert the following:

"Normally, newborn infants are only discharged from the facility in the custody of the parent(s). In the case of one or both parents effecting an adoption by **PRIVATE** means, in addition to making all necessary arrangements themselves, s/he will complete the appropriate State Health and Human Services form (AD22). This form provides for and authorizes the release on the infant from the hospital to a specified individual other than the mother/parent, in accordance with California Family Code #8700-9200. A copy of the AD 22 will be retained in the infant's medical record. Form AD 22 can be obtained in Patient Admininistration Department".

R. E. CONNORS
By direction

Distribution:
List A

NAVHOSP29PALMSINST 6300.1
21 March 1994

PATIENT ADMINISTRATION

MANUAL

Enclosure (l)

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CHAPTER 1

INPATIENT ADMINISTRATION GUIDELINES

1-1. Objectives

a. To achieve the lowest possible average length of stay, particularly for active duty patients, without effecting any compromise in the quality of healthcare services rendered.

b. To significantly reduce the total amount of non-effective time for active duty personnel and to return members to duty when the attending medical officer determines that the patient no longer requires occupancy of a general acute care bed.

c. To ensure that all inpatient medical records are administratively correct, complete and are in accordance with reference (a) through (c). All entries in the inpatient medical record are to be legible and in black ink.

1-2. Admission Procedures

a. Admission Authority

(1) Only privileged medical staff may admit patients to Naval Hospital, Twentynine Palms for treatment. Combined Armed Exercises physicians are not ordinarily granted admission privileges.

(2) In cases where there is disagreement concerning the service to which a patient is to be admitted, the matter shall be referred to the respective Director (Director of Medical/Surgical Services) for resolution.

b. Eligibility for Admission. Per reference (d), only those patients authorized by law or regulation shall be admitted to the hospital. All eligible personnel should be enrolled in the Defense Eligibility Enrollment Reporting System (DEERS) before being admitted or treated at this hospital. There is no allocation of beds for Veterans Administration beneficiaries at this hospital. Veterans Administration beneficiaries may only be admitted under special circumstances and in accordance with current directives. However, any patients requiring emergency medical care to preserve life or to prevent suffering may be admitted to the hospital without regard to eligibility. In cases of questionable eligibility, the admitting medical staff member

shall obtain clarification from the Head, Patient Administration Department during working hours or from the Officer of the Day (OOD) at other times, prior to admitting the patient.

c. Pre-Admission. Patients scheduled for routine and same day surgeries shall be directed by the attending physician to begin admission procedures not later than 0900 the work day prior to the admission. Obstetrical patients shall be directed by the Healthcare Provider to report to the admissions office for preadmission prior to the thirty-seventh week of gestation. Surgical cases may be delayed or canceled if the patient is not pre-admitted in a timely manner.

d. Admission History and Physical Examination

(1) Patients admitted to the hospital shall have a history taken and an appropriate physical examination performed by a medical staff member who has such privileges. The history and physical examination shall be thoroughly documented in the patient's inpatient record by the responsible HealthCare Provider of the medical staff.

(2) A complete history and physical examination shall be documented within 24 hours of admission. If a complete history and physical examination has been performed within 30 days prior to admission, the original or a legible copy of this report may be used provided there has been no subsequent change; or the changes have been recorded in the medical record at the time of admission using an interim note, dated and signed by the admitting member of the medical staff.

(3) When a patient is readmitted within 30 days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available on the inpatient ward.

(4) The medical record shall document a current, thorough physical examination prior to the performance of surgery. The history and physical examination must be entered into the medical record before discharge.

(5) If the patient's hospital stay is expected to be less than 48 hours at time of admission and of a minor nature, an Abbreviated Medical Record (SFÄ539) may be used, with the history and physical examination documented in the appropriate blocks.

(6) The admission note shall contain a statement of the conclusions or impressions drawn from the admission history and physical examination, and a statement of the course of action planned for the patient while in the hospital. This admission note must be written or endorsed by the responsible medical staff member within eight (8) hours of admission.

e. Admission Diagnosis. The admitting medical staff member shall indicate in the admitting orders the primary admitting diagnosis (established or provisional). If two or more conditions are present upon admission, the admitting physician shall designate, as the primary diagnosis, the more serious condition for which the patient was admitted. Under no circumstances will the admission diagnosis be stated as a procedure (such as, Appendectomy for Appendicitis).

f. Cancellation of Admissions

(1) Only the Head, Patient Administration Department may cancel an admission (Officer of the Day after hours.) A physician who wishes to cancel an admission must immediately contact the Head, Patient Administration Department giving a justification for this action.

(2) If cancellation of the admission is approved, the patient's name shall be removed from the Admission log and that patient's register number reissued. Cancellations are permitted only if the patient is admitted and released within the same census day.

(3) When cancellations occur, all care rendered shall be documented in the outpatient record. A cancellation discharge narrative summary may be legibly hand written on the Abbreviated Medical Record (SF-539) provided the extent of treatment rendered requires only a brief summation of care. The provider must document the reason for the admission and the reason the surgery was canceled.

g. Re-admission. Patients may be re-admitted using previous admitting documentation provided re-admission occurs within the same census day as the discharge or cancellation and the registration number has not been re-issued.

h. Orders

(1) When writing pre-admission or admission orders, the admitting staff physician is responsible for ensuring that appropriate diagnostic and therapeutic procedures are ordered and

written in a timely manner. Orders for patient consultations requiring discharge planning services should be initiated at the time of admission or as early as practical.

(2) Orders may be written by medical staff within the limits of their privileges at this Command. All inpatient orders written by non-physician staff members, with the exception of pre-operative anesthesia orders, must be countersigned by the responsible attending physician. Countersignature does not need to occur prior to implementation of the order.

(3) All inpatient attending physicians orders must be in writing and legible. An order shall be considered to be in writing if it is dictated to a registered nurse or pharmacist specifically assigned to function as a nonÄphysician healthcare provider and countersigned by the attending physician within 24 hours.

(4) Telephone orders shall be given only by a staff physician, certified nurse midwives or nurse anesthetist. The provider giving the telephone order shall ensure that the order is countersigned within 24 hours. The individual who is charged with the responsibility of executing a telephone or verbal order is authorized to verify the identity of the ordering physician, to question the validity or appropriateness of the order, and to request that the order be written. In the event of disagreement, the matter shall be immediately referred to the appropriate Directorate for resolution.

(5) All medication orders will be automatically discontinued when a patient goes to surgery. New medication orders must be written when a patient returns from surgery.

(6) All drug orders for narcotics, sedatives, steroids, antiplastics, hypnotics, anticoagulants, antibiotics and preparations containing ergot or its alkaloids will be automatically discontinued after 48 hours unless the order indicates the exact number of doses to be administered, the exact duration of medication, or the medication is reordered.

(7) Orders not to resuscitate (DNR or "NO CODE" orders) shall be accomplished in accordance with reference (e).

1-3. Consent. Guidelines for obtaining proper consent for treatment are contained in Chapter 3.

1-4. Progress Notes

a. Dated and timed progress notes must be recorded whenever there is a significant change in a patient's condition or treatment plan. Patients must have an evaluation documented in the chart by the provider, not less frequently than once daily. A summary note must be written on the day of discharge or transfer of the patient. All progress notes must be timed, dated and signed.

b. Opinions requiring medical judgment shall be written or authenticated only by medical officers. Progress notes by non-physician providers do not require medical staff countersignature.

c. The responsible medical officer must assure that the progress notes give a pertinent chronological report of the patient's hospital course and reflect any change in condition or results of treatment. Amendments to the medical record must adhere to medico-legal requirements. If at any time additional information is required after a specific entry is made, advance to the next available space on the Progress Note (SF-509) or Chronological Record of Medical Care (SF-600) and start the entry with the word "Amendment." Complete the entry as a routine record entry. Date, time and signature are required. Questions regarding amendments to medical records should be addressed to the Head, Patient Administration Department.

1-5. Corrections of Erroneous Entries. To correct an erroneous entry found on review of the medical record, a single diagonal line in black ink shall be drawn through the entry, making sure not to obliterate the entry. An additional entry shall be made on an SF-509 or SF-600 showing to what extent the original entry is erroneous. On the left side of the form containing the erroneous entry, the date and SF-509 or SF-600 page number of the correcting entry, as well as the signature, grade, and rate of the medical staff member making the change, shall be recorded and dated. If an error is made at the time a hand written entry is being placed on a medical record form, a single line shall in black ink be drawn through the erroneous word or phrase. The person making the entry shall then initial and date above the error and continue with the entry. Corrections of typographical or clerical errors (such as, transposition of numbers or letters, etc.) are authorized but must also be initialed.

1-6. Disposition Procedures

a. Upon discharge of ALL inpatients, the attending medical officer shall complete the Inpatient Admission/Disposition Record. This form must be completed prior to the disposition of the patient and shall indicate all principal and secondary diagnoses (not procedures); reasons for changes (e.g. revised, additional sequelae); and operative procedures performed. Acceptable disease and operative terminology that includes topography and etiology shall be utilized.

b. The "discharge note" shall be appropriately labeled and completed for all inpatients on the Doctor's Progress Notes. In addition, the Abbreviated Medical Record (SFÄ539) for hospitalizations of 72 hours or less and Interim Report of Inpatient Disposition (NH29P 6320/70) forms shall be appropriately completed for all active duty inpatients. Inpatient nursing staff shall make a copy of these documents. The original shall be placed in the inpatient record. The copy shall be given to the patient to take to Marine Liaison Office, Patient Administration Department.

c. The attending physician shall dictate a narrative summary for active duty patients hospitalized more than 72 hours or complete a SF-539 for hospitalization of less than 72 hours, prior to the patient's discharge from the hospital. The attending physician must dictate a narrative summary for patients other than active duty patients (supernumeraries) within one (1) day of discharge when hospitalization is greater than 72 hours. Abbreviated clinical records on supernumeraries shall be completed upon their discharge. A narrative summary must be dictated for all transfers and deaths, regardless of length of hospitalization.

(1) The narrative summary should concisely recapitulate the reason for hospitalization, the significant findings; primary and secondary diagnoses; the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient or family. Consideration should be given to instructions relating to physical activity, medication, diet and followÄup care. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology, such as "improved." When pre-printed instructions are given to

the patient or family, the record should so indicate. A copy of the narrative summary shall be forwarded by the Supervisor, Inpatient Records for inclusion in the patient's outpatient record.

(2) A completed and signed original narrative summary must ultimately be incorporated into the active duty health record. This requirement does not have to be fulfilled concurrently with the active disposition process; however, it shall be completed within ten working days following discharge. The Patient Administration Department shall closely audit narrative summaries, forwarding a delinquency list to the Medical and Surgical Directors.

d. The Abbreviated Medical Record (SF-539) may be substituted for the narrative summary in the case of patients with problems of a minor nature who require less than a 72 hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The discharge note in the progress section of the SFÄ539 must be complete and legible and shall include all discharge final diagnoses, procedures, date of discharge and any instructions that were given to the patient or family.

e. In the event of death, a summation statement should be added to the record either as a final progress note or as a separate resume. This final note should indicate the reasons for admission, the findings and course in the hospital, and the events leading to death.

f. Appendix A shall be utilized for the discharge process of all active duty inpatients. Appendix B shall be provided to each military member for presentation to their parent command and for subsequent inclusion in their health record.

1-7. Disposition Alternatives. The following disposition alternatives are applicable to all active duty members:

a. Discharge to Full Duty. An active duty member should be discharged to full duty when completely recovered and there are NO physical limitations imposed by the medical officer on the patient's performance of normal duties.

b. Continued Treatment as an Outpatient. Active duty members should be discharged to continued treatment as an outpatient when they have attained the maximum hospital benefit, but are not fit for return to full duty. Specific physical limitations and light duty are noted in Chapter 2.

(1) Light duty is a recommendation to the patient's command and the command is under no obligation to either accept the patient in a light duty status or to conform to the recommendation after accepting the patient.

(2) Light duty, upon being discharged from an inpatient episode of care, generally is not granted for more than fourteen days at a time for a period up to 30 days.

(3) QuartersÄOB status for pregnant and postpartum servicewomen is discussed in Chapter 2.

(4) Patients may not be discharged to a Sick-in-Quarters status.

c. Convalescent Leave

(1) Convalescent leave may be recommended for active duty patients only, provided that:

(a) The patient is not awaiting disciplinary action or separation from the service for medical or administrative reasons.

(b) The granting of leave is considered beneficial to the patient's health.

(c) The patient has not recovered to the extent of being fit for duty, but has received the maximum hospital benefit.

(d) The patient, in the attending physician's opinion, will not need hospital treatment during the contemplated convalescent leave period.

(e) Such leave will not delay final disposition of the patient.

(2) Convalescent leave shall not be in excess of 30 days (except for postÄpartum maternity leave which shall not exceed 42 days). Unusual circumstances wherein more than 30 days (42 days postpartum) convalescent leave is necessary requires the approval of the Commanding Officer. This authority may not be delegated.

(3) Procedures. Appendix B will be prepared by the attending physician and a copy forwarded to the Marine Liaison Office, Patient Administration Department. The original document is filed in the inpatient record. Convalescent leave may be granted in accordance with references (f) through (g) and will be executed in one of the following methods:

(a) Convalescent leave may be granted by the member's command upon a recommendation of the medical officer.

(b) Convalescent leave as delay in reporting may be granted by this command when a member's unit is deployed, the unit is not available to grant convalescent leave, or when the patient has a communicable disease and their return to the unit would jeopardize the health of the other members in the unit.

d. Active Duty Patients With Varicella. Every effort must be taken to limit varicella transmission to healthy, but susceptible patients. Per references (h) and (i), convalescent leave or subsistence at home (SAH) may be authorized for patients who reside at home. In all circumstances, patients residing in the bachelor quarters (BQ) will be admitted and placed in respiratory isolation. The Head, Occupational Health/Preventive Medicine Department shall be notified so that a disease alert report can be completed.

e. Unauthorized Absentees (UA). As soon as it is discovered that a patient is absent without authorization, the Head, Patient Administration Department (OOD after hours) shall be notified. If the patient is active duty, their command must be notified without delay. Command Journal entries are required when a patient goes UA, regardless of their status (i.e. active duty, dependents, retirees, etc.).

(1) An active duty patient in an unauthorized absentee status will be carried on the sick list for three days. On the third day the member will be discharged from the hospital to his parent command in an "absent without authorization" status. An active duty member may not sign out against medical advice. If an active duty patient leaves against medical advice it will be considered as an "unauthorized absence" and the Patient Administration Department (OOD after hours) shall be notified immediately.

(2) In the event a supernumerary patient expresses a desire to be discharged from this hospital against medical advice (AMA) of the attending physician:

(a) The Medical or Surgical Director (Medical Officer of the Day (MOOD) after hours) and the Head, Patient Administration (OOD after hours) shall be notified immediately. An entry shall be made in the command journal in all cases of discharge against medical advice.

(b) The attending physician shall:

1 Along with the Medical or Surgical Director attempt to dissuade the individual from leaving. If the patient insists upon leaving, the patient will be required to sign a "Statement of Refusal of Treatment Against Medical Advice" form, Appendix C, in the presence of at least two staff witnesses, one of whom should be the attending physician.

2 Ensure that appropriate entries are made in the patient's clinical chart. Should a supernumerary patient leave without the attending physician's consent, or fail to return to the hospital as specified by the attending physician, they shall be discharged at the time of departure.

3 Ensure that appropriate entries are made in the patient's clinical chart.

f. Combined Armed Exercise (CAX) Patients. All reasonable attempts will be made to notify the member's unit of an impending discharge.

(1) During normal working hours, the Marine Liaison Office is responsible for notification.

(2) After working hours, notification is the responsibility of the Officer of the Day. Patients requiring quarters and messing after discharge should be referred to the Combat Center's Command Duty Officer.

1-8. Subsistence-at-Home (SAH)

a. SAH is a privilege extended only to active duty patients when it becomes evident that they are not ready to return to full duty but require continuous outpatient treatment. Active duty members who reside in the BQ are not eligible for SAH. Requests by active duty patients for SAH will be closely scrutinized. If the patient no longer requires medical treatment, then a disposition alternative can be pursued with the Head, Patient Administration Department. Patients must be re-evaluated by the attending physician at least weekly and documentation of that visit shall be included in the patient's inpatient chart. A

patient in a SAH status shall remain on the ward census and a bed must be reserved for the patient. The inpatient chart of a SAH patient will be retained by the ward until the member is discharged from the hospital.

b. Eligible Patients

(1) Active duty patients in pay grades E-6 and above.

(2) Active duty patients in pay grades E-5 and below residing in the immediate vicinity (30 miles) of this hospital.

c. Ineligible Patients

(1) Patient in a restricted status.

(2) Active duty, officer or enlisted, residing in the BQ.

d. Procedures

(1) The patient shall submit a Special Request/Authorization Form, (NAVPERS 1336/3), in quadruplicate through the attending medical officer, appropriate clinical head of department, Head, Patient Administration Department (OOD after hours) and the Medical/Surgical Directorate.

(2) The Director of Medical Services or the Director of Surgical Services (MOOD after hours) will have final approval authority.

e. General Guidelines

(1) Patients shall not be granted this privilege during the first 24 hours of hospitalization and under no circumstances prior to the initial medical workup and initiation of treatment.

(2) Patients shall be required to remain within a reasonable distance of the Naval Hospital, as determined by their attending physician, and be readily available via telephone number.

(3) Patients requiring leave while at home shall return to this facility, for termination of their at home status and for discharge from the hospital.

(4) Patients SAH are in that status as a convenience to them; accordingly, orders issued upon completion of hospitalization shall state that government quarters were available during the entire episode of care.

(5) Patients are required to check out with the collection agent prior to departing on termination of SAH.

f. SAH may be granted in increments up to seven days and will not exceed 14 days in total.

1-9. Disposition Responsibilities. Patients shall be routinely discharged between 0730 and 1800, seven days per week. Medical officers should make reasonable attempts to discharge active duty members between 0800 and 1500, Monday through Friday, to allow sufficient time for processing orders and arranging transportation.

a. Attending Physician. Upon determining that a patient is ready for discharge, the attending physician shall:

(1) Dictate a Narrative Summary for patients hospitalized for more than 72 hours or complete an Abbreviated Medical Record, SF-539 for patients hospitalized less than 72 hours. All transferred patients require a transfer summary.

(2) Complete items 37 through 52 on the Inpatient Admission/Disposition Record.

(3) Complete and sign a discharge order and doctor's progress notes.

(4) Complete and sign the Interim Report of Inpatient Disposition (Active Duty) (NH29P 6320/70)).

b. Ward Personnel. Upon notification by the attending medical officer that an active duty member is being discharged, the Ward Personnel shall:

(1) Arrange the chart in chronological and numerical order by numerical form number order within the chart following the guidelines of Appendix D.

(2) Verify completion of doctor's discharge orders and progress notes.

(3) Complete and sign discharge nursing note.

(4) Complete and sign the Inpatient Clinical Chart Checkoff List (NH29P 6320/21A).

(5) On active duty patients, forward a copy of the completed Appendix B to the Marine Liaison Office, Patient Administration Department (OOD after hours).

1-10. Inpatient Medical Records

a. All staff members are accountable for prompt and appropriate completion of their medical record entries. Inpatient records must be prepared for forwarding to the Inpatient Records Division when the patient is discharged from the hospital.

b. Inpatient medical records are considered delinquent if they are incomplete 30 days after the day of the patient's discharge. An inpatient medical record is ordinarily considered complete when the required contents, including any required clinical resume or final progress note, are assembled and authenticated and when all final diagnoses and any complications are recorded, without use of symbols or abbreviations. Completeness also implies that the content of any dictated record has been transcribed and inserted into the medical record. In order to avoid delinquencies, all medical staff members shall check in with the Inpatient Records Division at least weekly to determine if there are record deficiencies.

c. Medical staff members are not permitted to complete a medical record on a patient in order to retire a record that was the responsibility of another staff member who is unavailable for a protracted or permanent time frame, usually over 30 days. No medical record shall be filed until it is complete, except on the recommendation of the Head, Patient Administration Department with the written approval of the Medical Records Review Committee (MRRC). The MRRC will document, in the minute proceedings, records that have been approved for filing, but are not totally complete due to the unavailability of the provider and the reason the record is incomplete. An additional note will be placed in the record stating it is filed incomplete by order of the MRRC with a date.

d. All completion requests and signatures for narrative summaries and operation reports shall be completed within five days after being placed in provider's box.

e. Medical staff members shall have access to patient medical records for bona fide study and research. This access must preserve confidentiality of personal information.

f. All Records after approval by Patient Administration removed from the Inpatient Records Division must be signed out by the medical staff member.

g. The Manual of the Medical Department, per reference (J) requires that the name and grade of medical officers and other authorized personnel making entries in the medical record shall be typed, printed or stamped under the signature. All healthcare providers are issued a stamp with the above identifying data which is to be used on all entries on the medical records where signatures are required. When the stamp is not available, the same information may be printed legibly below the provider's signature.

h. Medical records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a directing court order, subpoena, or statute. All medical records, both inpatient and outpatient, are the property of the United States Government. Records may not be removed or released without permission of the Head, Patient Administration Department in accordance with the Manual of the Medical Department and Manual of the Judge Advocate General. No member of the staff has the authority to release a medical record to a patient, their representative, or anyone else. No member of the staff has the authority to retain in their possession the medical record of any patient for longer than 24 hours. In case of readmission of a patient, all previous records shall be made available for the use of the medical staff when requested.

i. Inpatient charts may be retained on the ward for 24 hours after discharge to allow for review and completion of charts by nursing staff. When collected by Inpatient Records staff, the charts shall remain in Inpatient Records.

j. Procedures for Reporting Uncorrectable Record Discrepancies

(1) The Supervisor, Inpatient Records will maintain a record of all uncorrectable discrepancies. This list will identify the discrepancies by type and inpatient registration number. Monthly, a list of discrepancies will be forwarded, via Head, Patient Administration Department, to Chairman, Medical Records Review Committee.

(2) The MRRC will review the list, establish critical indicators and monitor variances of discrepancies.

(3) The Head, Patient Administration will assume approval authority for closing out records listed on the report. Approval will be noted on the discrepancy report. The report will then be returned to the Patient Administration Department. Once the approved report is received by the Inpatient Records Supervisor, then the records may be closed and filed with notations made in each record.

k. Obstetrical Patients

(1) Obstetrical hospitalizations over three days, must have a Narrative Summary (SF-502), History Part 1 and physical. If the Prenatal and Pregnancy Sheet (SF-533) is in the chart, a History Part 2 and 3 does not have to be completed. The patient must have a dictated Narrative Summary. If a patient has a Cesarean (C) Section, pre-printed postpartum orders are lined through and doctor's specific orders for a C-section are substituted. For normal obstetrical hospitalizations with an anticipated stay of less than three days, an Abbreviated Medical Record (SF-539) may be substituted for a History Part 1, 2 and 3.

(2) All repeat C-sections require a "long" History and Physical, a dictated Operation Report and a dictated Narrative Summary. "Long" History and Physical require a dictated narrative summary even if the patient was not hospitalized for more than 72 hours.

(3) All patients transferred to another facility must have a dictated Transfer Summary, no matter how short the period of stay.

1-11. Patient Checkout Procedures

a. Patients being discharged from the sick list will be given the ward copy of the Inpatient Data Card and instructed to checkout at those areas listed in Appendix A, as appropriate to their patient category. If the patient is incapable of performing the checkout procedure, either ward personnel or the patient's next of kin will assume responsibility for completing the checkout procedure. The ward copy of the Inpatient Data Card will be returned to the ward following completion of the checkout procedure.

b. Inpatient nursing staff will remind all patients, except retired enlisted and active duty Coast Guard, that they must make payment in person at the collection agent's office during normal working hours, from 0730 to 1600, Monday through Friday, or they will be billed for hospitalization charges. Enlisted patients will be reminded of the requirement for pay checkage if their bill is not settled at the time of discharge. Enlisted patients being discharged after hours who want to avoid pay checkage should return to the collection agent prior to 1200 of the next regular work day to pay their bill.

1-12. Liberty

a. Dependents and retired personnel may be authorized absences (liberty) from the hospital, without formal discharge, only in the most extreme circumstances and for periods up to 72 hours. In all other cases, the patient shall be formally discharged and readmitted upon return to the hospital. When absences are authorized in excess of 24 hours, subsistence charges or dependent's rates, as applicable for that period, shall be collected and the ward census shall reflect the bed as occupied. Prior to authorizing such absences, the attending physician shall advise patients of their physical limitations and of any necessary safety precautions and shall note in the clinical record that patients have been so advised. Appropriate entries regarding authorized absences shall be routinely recorded in the patient's clinical record and on ward reports.

b. Processing authorized absence (liberty) requests may be approved by the Director of Medical Services or the Director of Surgical Services (MOOD after hours) after endorsement by the attending Medical Officer and Head, Patient Administration Department (OOD after hours).

1-13. Leave. Regular leave will not be granted to inpatients except under extreme circumstances. This request requires approval by the Commanding Officer.

CHAPTER 2

MEDICAL REVISED DUTY STATUS

2-1. Purpose. To issue policy and procedures for utilization of Medical Revised Duty Status such as bed rest, sick in quarters, light duty, OB - Quarters, and convalescent leave for ambulatory care in accordance with reference (j).

2-2. Policy. Medical Revised Duty Status is used by healthcare providers to recommend to an individual's command that the member be placed in a Sick-In-Quarters (SIQ), Light Duty (LD), or Convalescent Leave status to allow sufficient time for patient recuperation, when hospitalization is not indicated. Light Duty should not be confused with Limited Duty. Limited Duty requires a Medical Board determination and is for periods of 30 days or more.

2-3. Action

a. Physicians, Physician Assistants (PAs) and Nurse Practitioners (NPs) are authorized to:

(1) Recommend that a patient be placed in an SIQ status not to exceed 96 hours under normal circumstances. This time may be extended up to a maximum of 14 days with prior approval from the Director of Medical Services or the Director of Surgical Services. Appendix E is a guideline of conditions which may require more than a normal duration of SIQ. Anyone placed in an SIQ status shall be re-evaluated prior to returning to duty.

(2) Recommend that a patient be placed on light duty or convalescent leave, for periods not to exceed 30 days. Such patients will be re-evaluated by a physician, PA, or NP every two weeks until returned to full duty. Members requiring light duty or convalescent leave beyond 30 days require medical board determinations for Limited Duty.

b. Independent Duty Corpsmen (IDCs) are authorized:

(1) To recommend that a patient be placed in an SIQ status not to exceed 24 hours, or 48 hours after consultation with a physician. If SIQ is to exceed 48 hours, the patient must be evaluated by a physician. All persons placed in an SIQ status shall be revaluated prior to returning to duty.

(2) To recommend that a patient be placed in a LD status not to exceed 14 days. If LD is to exceed 14 days, the patient must be evaluated by a physician.

c. All healthcare providers shall:

(1) Give each patient placed SIQ specific instructions on self-care and follow-up. The member will be told the intervals at which they should report back to the Naval Hospital. The healthcare provider should be specific as to what symptoms warrant immediate return to the Naval Hospital.

(2) Prior to recommending SIQ or LD status, the healthcare provider must determine that the member has a safe environment in which to recuperate.

d. All personnel recommended for SIQ or LD shall be required to present a copy of the Medical Revised Duty Status Form (Appendix F) to their parent command's Officer of the Day (OOD). If, in the opinion of the healthcare provider, the patient should return to quarters without returning to the parent command, the healthcare provider must notify the Naval Hospital OOD who will notify the Duty Officer of the patient's parent command of the patient's status.

e. Head, Occupational Health/Preventive Medicine shall take necessary action to ensure that Disease Alert Reports are completed for all contagious diseases, including varicella.

2-4. Convalescent Leave

a. Under only the most extreme circumstances, with prior approval from the Director of Medical Services or the Director of Surgical Services, physicians may recommend convalescent leave for an active duty outpatient. SIQ or LD options will be fully exhausted before outpatient convalescent leave is considered appropriate. The member need not be admitted in order to be recommended for convalescent leave.

b. Convalescent leave vice sick in quarters is appropriate when the member's presence in the area of their duty station is not required during the period of convalescence. Convalescent leave should be considered when no medical or surgical follow up is required during the period of leave and the member would benefit from the care provided by family members who live outside of the geographic area. This is particularly beneficial of members who live alone in the BQ.

c. Convalescent leave is only a recommendation by the Medical Officer and the parent command must approve all leave requests. Patients must be physically qualified to report back to their assigned duty stations to process their leave request.

2-5. Active Duty Patients With Varicella. Efforts must be taken to limit varicella (chicken pox) transmission to healthy, but susceptible adults by minimizing exposure of other persons to varicella patients. Convalescent leave or SIQ status may be authorized for those personnel residing at home provided there is someone to monitor their status. Personnel residing in the BQ will be hospitalized and placed in respiratory isolation until deemed non-infectious by the medical officer. Reference (i) requires that a Disease Alert Report be completed for all varicella cases among active duty personnel.

2-6. Pregnant Active Duty Members

a. Active Duty Navy

(1) Pregnant active duty Navy members may be placed in sick in quarters status referred to as Quarters-OB status at any time during the pregnancy. Unless prescribed earlier, pregnant service women are usually placed in a light duty status between the 36th and 38th week of pregnancy.

(2) Following an uncomplicated normal delivery, a member will normally be authorized 42 days of maternity leave.

(3) Additionally, light duty may be prescribed for a maximum of two weeks for those servicewomen having completed maternity leave, who are ready to report to the command, but can only work part time.

b. Active Duty Marines

(1) Following an uncomplicated normal delivery, a member will normally be authorized 42 days of maternity leave.

(2) A woman Marine needing additional personal time after being medically certified fit for duty may request regular leave.

(3) Pregnant active duty Marines will remain in a full duty status until a medical officer certifies that full duty is medically inadvisable. At that time they will be placed in a medical light duty or no duty status, or hospitalized, at the discretion of the medical officer. Pregnant Marines normally

will not be placed in a no duty status earlier than four weeks prior to the estimated date of delivery. They are expected to return to full duty as soon after delivery as the medical officer certifies them medically qualified.

2-7. Staff Personnel. Except for patients being followed in the Obstetric Clinic, all Naval Hospital staff personnel must be seen in Military Sick Call for routine conditions and injuries. When SIQ or LD is recommended the following actions shall be taken:

a. Officers will present the original of the Medical Revised Duty Status Form to their Director for approval.

(1) The appropriate Director will notify the Executive Officer.

(2) The Director will ensure that a copy of the approved form will be delivered to the information desk for entry into the Command Journal.

b. Enlisted personnel will present the original of the Medical Revised Duty Status Form to the Head, Manpower Management Department for approval after presenting the chit to their department head. The Head, Manpower Management Department shall:

(1) Ensure a copy of the approved form will be delivered to the information desk for entry into the Command Journal.

(2) During normal working hours will ensure that the OOD is immediately notified of duty section personnel being placed SIQ or on LD.

CHAPTER 3

CONSENT TO MEDICAL TREATMENT

3-1. Purpose. To set forth policy and procedures for obtaining appropriate consent to medical treatment from all persons who present themselves for medical treatment.

3-2. Policy. All patients have the right to be informed of the nature of medical treatment, the risks, the complications and the alternative forms of medical treatment before submitting to medical treatment. In the case of minors, with certain exceptions outlined in this chapter (such as in an emergency), the right of informed consent belongs to the natural parent or other person having legal custody or power of attorney. In the case of emergency situations, the parental right to informed consent is not terminated, but is substituted with implied consent. The attending physician is responsible for providing the patient or parent with all the necessary information in language that is understandable to the layman.

3-3. Background. The laws of the State of California, as set forth in reference (K), apply to the obtaining of informed consent at this Naval Hospital. The law also sets forth specific provisions concerning the treatment of minors. In cases of family planning, reference (l) also pertains. Appendix G provides a list of legal consent requirements for medical treatment of adults and minors in various circumstances and will be used as a guide in obtaining consent.

3-4. Discussion

a. Informed consent involves an interchange of language by which the patient, or person authorized to act on the patient's behalf, specifically states that consent is given to the proposed medical care. At a minimum, the physician must advise the patient of the nature of the procedures, its risks and possible alternative methods of treatment. This is the doctrine of "informed consent," and it is based on the fact that every competent adult has the right to decide what will be done with their own body, even though morbidity or mortality may result from refusal to consent.

b. If a medical emergency exists, an adult or minor may be treated without his consent under the legal doctrine of "implied consent." The theory of implied consent is that the patient would consent if he were able or that the parent or legal guardian would consent if present.

c. Informed consent shall be obtained and recorded on the SF-522 when any of the following procedures are involved, for both inpatients and outpatients:

(1) Any major or minor surgery which involves an entry into the body, either through an incision or through one of the natural body openings.

(2) Any procedure or course of treatment in which anesthesia is used, whether or not an entry into the body is involved.

(3) Any nonoperative procedure which involves more than a slight risk of harm to the patient, or which involves the risk of a change in the patient's body structure.

(4) All other procedures which, in the opinion of the attending physician, head of the department, or Commanding Officer, require a written consent. Any question as to the necessity or advisability of obtaining a written consent from or on behalf of the patient should be resolved in favor of procuring such a consent.

3-5. Responsibilities

a. The Attending Medical Officer shall obtain an informed consent form from the patient or parent.

b. The Head, Patient Administration Department shall assist the attending physician with resolving administrative problems that arise in obtaining an informed consent, during normal working hours. After normal working hours, the Officer of the Day shall assume this responsibility.

c. The Director of Medical Services or the Director of Surgical Services shall assist the attending physician with resolving any problems which arise that are clinically related.

3-6. Definitions. The following definitions apply:

a. Adult. Any person, male or female, who has reached the age of 18 years.

b. Minor. Any person, male or female, under the age of eighteen (18). A minor is considered to be incompetent to consent to medical treatment except as otherwise allowed by law. Delineation of the different categories for "minor" is addressed within paragraph 3007 of this chapter.

c. Consent. Voluntary agreement by a person in the possession and exercise of sufficient mentality to make an intelligent choice to do something proposed by another. The consent shall be in writing and placed in the patient's chart because a written document is considered to be the "best evidence" in the event of future litigation.

d. Emergency Care. Medical treatment of patients with severe, life threatening, or potentially disabling conditions that require immediate intervention to prevent undue suffering or loss of life or limb.

3-7. Procedures

a. General. An informed consent shall be obtained from all patients presenting themselves for treatment. In the case of minors, this consent shall be obtained from their parent, legal guardian or other person authorized to give consent.

(1) If the patient is unable to give consent or the person who must give consent is not present, the following actions shall be taken:

(a) Documentation of this fact shall be made in the patient's record.

(b) Every effort shall be made to locate the appropriate person and have him appear in person to give the consent.

(c) If the required person is unable to appear in person and the medical treatment is essential, although not rising to the level of an "emergency," consent may be obtained by telephone. This shall be accomplished in the following manner:

1 The attending physician, (not other hospital personnel) shall explain the treatment planned, risks involved and alternative forms of treatment and then request permission to treat the patient. If surgery is required, the name of the surgeon and/or associates or assistants and the specified procedure shall be provided to the person providing the consent.

2 All information discussed shall be recorded in the patient's record and signed and dated by the physician who discussed the case. In addition, it shall be signed and dated by a witness who has listened to the conversation on an extension phone.

3 In limited situations, a telegram or FAX may be the only means of obtaining consent. The person giving consent may send telegram or fax stating the following information: "Grant permission to treat John Doe." The document must contain the name of the person giving the consent and their relationship to the patient. Upon receipt, the consent document shall be placed in the patient's record.

(2) In the case of minors, if the natural parents or legal guardians cannot be located, then the procedures outlined in Appendix H shall be followed to obtain a court order, so that the necessary treatment may be provided.

b. Adult. When an eligible adult presents himself for medical treatment, consent to treatment is necessary and shall be given by the following:

(1) An adult must give his own consent.

(2) An adult mentally competent, but physically unable to sign consent form. He must give his/her own consent to the medical treatment. The procedures, risks, complications and alternatives shall be explained to the patient by the attending physician. If the patient can make a mark (such as an "X"), he shall do so on the consent form. This shall be witnessed by the attending physician and an additional person. Also, the patient's physical inability to make any mark other than an "X" shall be noted on the form by the attending physician. If the person cannot make a mark, but verbally consents, this shall be indicated on the consent form by the attending physician and verified in writing by at least one witness.

(3) An adult mentally competent, but unable to write or speak. He must give his own consent. The procedures, risks, complications and alternates shall be explained to him by the attending physician and the patient shall acknowledge he understands and consents by a head nod, squeeze of the hand, etc. This shall then be recorded on the consent form by the attending physician and signed by the physician and a witness.

(4) Married adult. The spouse lacks legal capacity to consent for the patient unless such spouse enjoys other legal status under the law (e.g., legal guardian or conservator). If the operation involves a termination of pregnancy or sterilization, reference (l) applies, and written consent of the spouse is not required.

(5) Incompetent adult patient, under guardianship or conservatorship. If a guardian or conservator "of the person" has been appointed, said guardian or conservator may consent to treatment. However, when the patient explicitly refuses such treatment, the physician shall require that the guardian or conservator obtain specific court authorization before proceeding. A certified copy of the official letter of guardianship or conservatorship shall be obtained and placed in and become a part of the patient's permanent medical record, prior to providing treatment.

(6) Incompetent adult patient, not under guardianship or conservatorship. Where the attending physician is of the opinion that the patient is either temporarily or permanently incompetent and emergency treatment is not indicated, treatment shall be withheld until either the patient regains competency or a guardian or conservator "of the person" has been appointed. One exception to this situation is when a legal guardian has not been appointed. Such a situation is true in situations when the patient has executed a "Durable Power of Attorney for Healthcare," which provides authority for someone else to make valid medical decisions for an otherwise comatose or incompetent person without either a guardianship of conservatorship in place. In this situation, to facilitate the treatment of the patient, it is acceptable for the following to give consent: the patient's spouse or, if he cannot be located, an adult child of the patient or the patient's brother or sister. However, the person giving the consent shall be made aware of the necessity of being appointed the legal guardian and be advised to begin the legal proceedings at once.

(7) Adults with certain religious faiths (such as, Jehovah's Witnesses) may not believe in medical treatment or certain aspects of medical treatment (e.g., blood transfusions). If the situation involves a woman who is pregnant, a court order generally can be secured to protect the life of the fetus with the additional benefit of probably saving the mother's life. Procedures for obtaining a court order are outlined in Appendix H. Consultation with the Commanding Officer is required for all such incidents.

c. Minors. When a minor presents himself for treatment, consent to treatment is necessary; however, because a minor is ordinarily considered to be legally incapable of consenting, an adult will have to consent. The adult is usually the natural parent but can be the legal representative or conservator. When the minor is mature enough to understand the treatment procedure, but not legally able to give his own consent, he shall sign the consent form in addition to the parent or legal guardian. In obtaining consent for treatment of minors, the following guidelines shall be followed:

(1) Minor. Cannot be treated without the consent of one of the natural parents or legal guardian, with the exception of the situations presented in paragraph 3-7. If a legal guardian has been appointed for the minor, the guardian has the legal capacity to consent to treatment and such consent must be obtained. A certified copy of the official letter of guardianship shall be obtained and placed in and become a part of the minor's permanent medical record, prior to proceeding with treatment.

(2) Minor with divorced parents. The consent of either parent is sufficient; however, if there is a conflict between the parents, the one having legal custody has the final authority. Therefore, every attempt will be made to get the consent of the parent having custody. Custody rights are normally specified in court decree.

(3) Adopted minor. The basic rule relating to consenting for children is that only the natural parents can consent for their children who are under 18 years of age. However, if the child has been legally adopted (by order of the court) the adoptive parents may consent. If the child has not been legally adopted, a step-parent cannot validly consent.

(4) Minors living away from home (emancipated minor). Under California law, a minor may only be emancipated if in United States Armed Forces, married or, in receipt of a court order. The California Civil Code enables a minor to petition the court for emancipation; and, if the petition is sustained, the Department of Motor Vehicles will issue an identification card which states that the minor is emancipated. A minor shall be asked if he has such an identification card; however, a minor shall not be denied necessary treatment because he does not have a card. In the absence of evidence to the contrary, affirmations of emancipations may be made utilizing the Emancipated Minor -

Information form, Appendix I, and may be assumed to be correct without independent verification. The parents, guardian or conservator incurs no obligation to pay in this case unless they have personally consented.

(5) Minor in custody of foster parents. Foster parents do not have legal capacity to consent to medical treatment for minors unless they have an authorization to give consent by the agency having legal custody of the minor. Evidence of such authority, in writing, shall be obtained before proceeding with treatment.

(6) Abandoned minor. It must first be established that the minor has been deserted by the parents. If this is so, then the procedures outlined in Appendix G shall be followed to obtain a court order so that the necessary treatment can be provided.

(7) Minor pupil. If a parent or guardian cannot be reached, a physician in the hospital may provide reasonable treatment without consent to any child enrolled in any school, in any district, when the child is ill or injured during regular school hours. This provision does not apply if the parent or guardian has previously filed with the school district a written objection to any medical treatment other than first aid. Verification with the pupil's school is recommended.

(8) Special Power of Attorney For Consent For Medical Care. Either parent of a minor (if both parents have "legal custody") or the parent having "legal custody" or the legal guardian, may authorize another adult to consent to the minor's medical care by using Appendix J. If the parents cannot be located, then the procedures outlined in Appendix G shall be followed to obtain a court order, so that the necessary treatment can be provided.

(9) Minor suspected of having been abused or neglected. An examination may be performed by a physician without consent of parents or legal guardian, if the minor is suspected of being abused/neglected. The examination does not include pelvic examination, blood testing or x-rays. Should these be necessary for complete assessment and consent is denied or unobtainable, a court order shall be obtained in accordance with the procedures contained in Appendix G.

(10) Minor of a religious faith (e.g., Jehovah's Witnesses). If such a minor is a member of a faith that does not allow medical treatment, and the minor, if allowed by law to consent, or the parents or legal guardian will not consent to the

necessary treatment, the Head, Patient Administration Department or the Officer of the Day (after normal working hours) shall be contacted immediately. Procedures contained in Appendix G shall be utilized to obtain a civil court order to allow the necessary medical treatment after consulting with the Commanding Officer.

(11) Minor born out of wedlock. The natural parent has the legal capacity to consent to medical treatment for the minor. The natural father has the legal capacity to consent to treatment if it is established that he is the natural father. A copy of the judgment or order o£ a court determining the existence of the father and child relationship shall be obtained before accepting the consent of the alleged natural father. A certified certificate of live birth identifying the father will suffice.

(12) Children of minor parents. A minor parent can validly consent to medical or surgical treatment of his or her child.

(13) Minors on active duty with U.S. Armed Forces. Any minor, regardless of age, while serving on active duty with any branch of the armed services, may personally consent to all medical care of any nature.

(14) Minors suffering from a reportable disease. When a minor of 12 years of age or over has a communicable disease of the type which must be reported to the local health officer, the minor is able to give valid consent for treatment relating to reportable disease. Parental consent is not necessary. The attending physician shall ensure that the appropriate symptoms of the communicable disease are present and that they are properly recorded in the patient's record. The minor shall be aware that he can and will be treated without parental consent and that the treatment will not be discussed by the physician with the minor's parent or legal guardian. In addition, the minor shall also be advised that although the treatment will not be discussed, it will be recorded in the minor's medical record and that the parent or legal guardian has access to the information contained in this medical record.

(15) Minor as rape or sexual assault victim. Any minor, regardless of age, who is alleged to have been raped or sexually assaulted, may give consent to the furnishing of hospital medical and surgical care related to the diagnosis or treatment of such conditions. The consent of the minor's parent or legal guardian is not necessary. The professional person rendering the typical treatment shall attempt to contact the minor's parent or legal guardian and shall note the date and time of such contact or, if

unsuccessful, when contact was attempted. The professional person need not make this contact if he reasonably believes that the parent, parents or legal guardian committed the sexual assault on the minor. The professional person shall notify appropriate law enforcement agencies as well as the Family Advocacy Representative in accordance with reference (m).

(16) Minors with drug or alcohol-related problems. A minor, 12 years of age or older, may consent to medical care and counseling related to the diagnosis and treatment of a drug or alcohol related problem. The consent of parents of such a minor is not necessary, and, unless they participate in the counseling program related to such treatment, they will not be liable for payment of the minor's care.

d. Refusal of consent. If an adult refuses to consent to medical treatment, the attending physician shall counsel the patient of all the risks involved and document the refusal of treatment and the counseling in the patient's record. If the patient is an active duty member and refuses to consent to treatment, the Head, Patient Administration Department or the Officer of the Day (after normal working hours) shall be contacted so that the member may be counseled.

e. Emergency Treatment

(1) If a medical emergency exists,an adult or minor may be treated without his consent, under the legal doctrine of "implied consent." The theory of "implied consent" is that the patient would consent if he were able, or that the parent or legal guardian would consent if he were present. The doctrine of "implied consent" may not be used to negate the refusal of a competent patient to submit to medical treatment even though an emergency may exist. If a competent patient refuses necessary treatment, a detailed notation shall be made in the medical record, refer to paragraph 3-7.

(2) In determining if an emergency exists, the attending physician shall consider the following guidelines:

(a) Determine if the treatment is immediately required and necessary and that delay in treatment could reasonably be expected to result in death, disability or probable deterioration or aggravation of the patient's condition.

(b) Assess the probable time frame involved in obtaining the necessary written consent, weighed against the possibility that such a delay in obtaining consent would jeopardize the health of the patient.

(c) Obtain additional medical consultations to the existence of a true medical emergency. This is a corroborating opinion as to the fact that an emergency does exist.

(d) In general, physicians shall recognize that it is better to "err on the side of life" and render such treatment as they feel is medically indicated rather than withhold needed treatment because of undue fear of legal ramifications.

(e) Render only that treatment relative to the true emergency and necessary for its adequate resolution or stabilization.

(f) After the emergency has been treated, the attending physician shall ensure that the treatment rendered is recorded in the patient's record.

3-8. Family Planning and Abortions

a. Reference (n) prohibits the performance of abortions except where the life of the mother would be endangered if the fetus were carried to term. Performing elective abortions in Naval medical treatment facilities is not authorized. Certification of medical need must be completed in compliance with reference (n) and documented in the patient's medical record.

b. Informed consent will follow the procedures outlined above and will include documented counseling of alternate treatment modalities and religious or psychological counseling as desired by the patient or deemed necessary by the healthcare team.

c. Preoperative counseling will allow the patient sufficient time to consider her decision. In non-emergency cases, counseling must be provided no less than 24 hours prior to the procedure. Emergency cases are exempt from the time requirement.

d. Minors receiving pregnancy care or abortion. Reference (o) sets forth State of California policy concerning family planning services, contraception, and abortion. Written consent from the minor's sponsor, parents or legal guardian is required for abortions. The minor can be treated for family planning or

contraceptions without parental consent and the treatment will not be discussed by the physician with the minor's parent or legal guardian. The minor shall be advised that although the treatment will not be discussed, it will be recorded in the minor's medical record and that the parent or legal guardian has access to this medical record. Minors will be encouraged to discuss treatment plans with parents or sponsors in an effort to promote family unity.

e. Per reference (l), sterilization of non-emancipated minors or persons of questionable mental capacity may be performed only under a court order of competent jurisdiction.

3-9. Elective Sterilization. Elective sterilizations are defined as any medical treatment, procedure or operation, excluding hysterectomies, for the purpose of rendering a person incapable of reproduction. Elective sterilization may be performed only when the following conditions are met:

a. Informed consent has been obtained from the patient.

(1) The patient must not be in a condition or mental state in which judgement is significantly altered, whether due to the influence of alcohol or other substances that affect the individual's state of awareness.

(2) The patient must not be in labor nor less than 24 hours post-partum.

(3) The patient must not be seeking an abortion or having obtained an abortion within the previous 24 hours.

b. The sterilization consent form has been signed by the necessary parties.

c. Thirty days, but not more than 180 days, have passed since the Sterilization Consent Form (State of California-Health and Welfare Agency Form) was signed by the patient.

d. An elective sterilization may be performed less than 30 days after the patient signed the consent form in the following circumstances:

(1) Informed consent was given and the Sterilization Consent Form was signed at least 30 days before the intended date of sterilization; and

(2) The physician certified that at least 72 hours have actually passed since informed consent was given and the Sterilization Consent Form was signed; and

(3) The physician describes the emergency (for abdominal surgery) or indicates the prior expected date of delivery (for premature delivery) on the Sterilization Consent Form; or

(4) The patient voluntarily requests in writing that the 30 day waiting period be waived to no less than 72 hours.

e. An individual has given informed consent only if the person who obtained consent for the sterilization procedure has:

(1) Provided answers to any questions the individual to be sterilized may have concerning the procedure.

(2) Provided verbally all of the following to the individual to be sterilized:

(a) Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.

(b) A full description of available alternative methods of family planning and birth control.

(c) Advise that the sterilization procedure is considered to be irreversible.

(d) A thorough explanation of the sterilization procedure to be performed, including:

1 A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.

2 A full description of the benefits or advantages that may be expected as a result of sterilization.

3 Approximate length of stay.

4 Approximate length of time for recovery.

5 Information that the prescribed procedure is established or new.

6 Advice that the sterilization will not be performed for at least 30 days, except under specified circumstances.

7 The name of the physician performing the procedure prior to administering pre-anesthetic medication, and the reason for any change of the performing physician.

3-10. Procedures for Obtaining a Court Order for Medical Treatment for Minors

a. The attending physician shall complete Appendix (H), Physician's Verification of Permission to Treat a Minor, and call the San Bernardino County Department of Social Services and request authority to perform the medical treatment.

b. The Department of Social Services will notify local law enforcement who will take the minor in custody pending approval from the court for commencement of treatment. Social Services will contact the Court and notify the Naval Hospital physician of the Court's decision.

3-11. Guidelines for Completing Standard Form 522

a. Identification. In the space provided, enter the type of procedure(s) to be performed using accepted medical terminology.

b. Statement of Request

(1) In the spaces provided, enter a description of the operation or procedure in laymen's language. The physician that performs or directs the operation shall be listed here in the appropriate space.

(2) This is an important consideration regarding the performance of additional procedure(s) as deemed necessary in the judgment of the professional medical staff during the course of the primary surgical procedure. Since this information requires thoughtful acknowledgement, the patient or their sponsor shall initial this element indicating their understanding.

(3) This element regards the administration of anesthesia during the procedure(s). Similarly, the patient or sponsor shall indicate their understanding by initialing the item.

(4) In the space provided, the patient's physician shall list any exceptions to the surgery or anesthesia.

(5) Since some tissue may necessarily be removed during surgery, the need for appropriate disposal of such is readily apparent. This element shall be initialed by the patient or his sponsor indicating their understanding.

(6) In the interest of professional education, from time to time photographs or movies will be made during a patient's surgery. It should be noted that such reproduction will be used only for medical study and the name of the patient or his family will not be used to identify said pictures.

(7) If any of the above mentioned information is deemed inappropriate, simply cross out that part.

c. Signatures

(1) This element shall be signed by the physician indicating that they have counselled the patient regarding the proposed procedure described above. The physician shall use their stamp in addition to the signature.

(2) This element is to be signed by the patient indicating that he understands the nature of the surgical procedure and thereby requests that the procedure be performed. The signature of the patient shall be witnessed by someone (excluding the members of the operating team) and said witness shall also provided their signature.

(3) In the event that the patient is a minor unable to give consent for the procedure to be performed, the patient's sponsor will provide authorization by signature. This authorization shall be witnessed and a signature shall be provided by the witness. The witness shall not be a member of the operating team.

(4) A proper date and time entry shall accompany each signature in the space provided.

d. A patient identification block is provided in the lower left corner of the SF-522. The patient's hospital card, if available, shall be used for this information. Otherwise, type or print the last name, first name and middle initial of the patient; the member's or sponsor's social security number; date of birth and his grade, service and status.

CHAPTER 4

TEMPORARY LIMITED DUTY (TLD) MEDICAL BOARD REPORT PROCEDURES

4-1. Purpose. To set forth policies and procedures for Naval Hospital, Twentynine Palms, on the assignment of active duty Navy and Marine Corps members on Temporary Limited Duty (TLD) per references (g) and (m).

4-2. Background. There are many enlisted members who should be on a TLD status, but are delayed in their processing because of the tremendous workload of the physicians at this medical treatment facility (MTF). Reference (j) provides requirements for assignment to TLD status. Reference (p) allows a single physician medical board to be convened to evaluate and report on any enlisted member of the Navy or Marine Corps, using the Abbreviated Temporary Limited Duty Medical Board Report (NAVMED 6150/5) Form.

4-3. Policy. Per reference (p), a single physician medical board may be convened on any enlisted active duty member of the Navy or Marine Corps who is temporarily incapable of fully performing his or her duties due to physical or mental impairment.

a. Documented consultation with the clinical specialist is required. The NAVMED 6150/5 will be used to document this process and will only be used when the member is expected to return to full duty after an adequate period of treatment.

b. The NAVMED 6150/5 is intended to serve as a basic outline of the complete medical summary recorded in the member's health record, not as a substitute for detailed documentation of the condition in the member's health record. Sufficient entries documenting the nature and circumstances of the illness or injury, its course, prognosis and treatment must be contained in the member's health record.

c. A single physician medical board may only be convened when the member suffers from an uncomplicated illness or injury which makes him or her temporarily unable to perform duties to which he or she is assigned or expected to be assigned, but will most likely be fit for full duty after an adequate period of treatment not to equal or exceed 12 months.

(1) For Navy member's the TLD can be recommended up to 12 months, but not to exceed 12 months.

(2) For Marine members, in accordance with reference (j), an abbreviated TLD board can be used to recommend limited duty for up to 6 months. A Medical Officer can renew the limited duty for up to 6 months (not to exceed a total of 12 months) by recommending an additional period limited duty by documenting it on an SF-600. The Head, Patient Administration will ensure that a copy of the SF-600, along with any supporting medical documentation are forwarded to CMC for review.

d. When the TLD period is expected to exceed 12 months, a long-form Limited Duty Board must be convened per reference (n). Assignment to TLD status will normally not be for less than a six month period. Only staff military physicians privileged at Naval Hospital, Twentynine Palms, may initiate the Abbreviated Limited Duty Medical Board.

4-4. Action

a. Physicians. After determining the requirement for TLD status, the physician completes the top half of the NAVMED 6150/5 leaving the member's and Convening Authority's signature blocks blank, then forwards it, with the member's health record, to the Medical Boards clerk, Admissions Office, Patient Administration Department. The patient is also directed to report to the Medical Boards Office.

b. Head, Patient Administration Department shall:

(1) Review the NAVMED 6150/5 and the member's health record to ensure recommendations are consistent with current policies. If the Patient Administration Officer believes a long-form medical board is required, he shall notify the convening authority (CA) and explain the requirement to the physician. If the CA concurs with the need for a long-form medical board, then the physician shall dictate a medical board.

(2) Counsel and obtain the member's signature on the NAVMED 6150/5.

(3) Complete Patient Administration Endorsement on NAVMED 6150/5.

(4) Obtain the CA's signature on NAVMED 6150/5.

(5) Direct the member to report to their appropriate parent command for endorsement prior to presentation to their personnel office with original NAVMED 6150/5. In the case of Navy members serving on type 2 or 4 duty, a command endorsement is not required nor desired as the member must be made available for orders.

(6) Track members assigned to TLD status to ensure timely re-evaluation and proper final disposition.

CHAPTER 5

DISENGAGEMENT OF SUPERNUMERARY PATIENTS

5-1. Background

a. Generally, a patient whose condition is such that this Hospital cannot provide adequate care will be transferred to an adjacent Uniformed Services Military Treatment Facility capable of providing such care. In some instances, however, it is advisable that the primary responsibility for management of a patient be released by this hospital and assumed by a civilian provider. This procedure is known as disengagement.

b. If the disengaged patient is eligible for CHAMPUS, benefits can be extended under that program, in accordance with reference (q).

c. In order to protect supernumerary patients against unexpected financial expenses and to protect the hospital against undue expenditures of Operation and Maintenance Funds, it is imperative that patients be disengaged prior to referral to civilian healthcare facilities.

d. Disengagement applies only to supernumerary patients. Active duty patients shall not be transferred to a civilian facility except in extraordinary circumstances when approved by the Commanding Officer. A Disengagement Notification Form (NAVMED 6320/30) will be filled out on all dependents and retired patients who are being transferred to another medical facility. This will be done even though the patient is being transferred to a military medical facility, regardless of in-patient or out-patient status.

5-2. Action

a. The attending medical officer shall be responsible that proper documentation is recorded in the patient's medical record when a patient is disengaged.

b. Disengagement that takes place during normal working hours shall be referred to the Health Benefits Advisor (HBA) who will brief the patient or sponsor, and initiate the Disengagement Notification Form (NAVMED 6320/30).

c. After normal working hours, weekends and holidays, disengagement shall be accomplished by the Officer of the Day. A Disengagement Notification Form, shall be filled out in quadruplicate. The original shall be returned to the HBA on the next working day and the copies given to the patient or sponsor.

d. The HBA shall ensure that all completed disengagement forms are filed for future reference.

5-3. Supplemental Care. When medical management of a patient is retained by the Naval Hospital and required care or services are not available at this facility any additional material, professional diagnostic or consultative service, or any other personal services ordered and obtained by a military provider for the care of that patient are considered supplemental care.

a. Policy

(1) When, during the initial evaluation or course of treatment of eligible beneficiaries, the attending physician determines that required services are beyond the capability of the Naval Hospital, they will attempt to arrange for care from another Uniformed Services Medical Treatment Facility where the needed care is available. Normally, Naval Hospital, Camp Pendleton and Naval Medical Center, San Diego will be used as the referral facilities.

(2) Ordinarily, referral for supplemental care or services will be used only when determined by the attending physician and approved by the Commanding Officer or their designee that extreme necessity exists. When it is necessary that the primary responsibility for medical management of the patient be retained by the attending military physician, they must make arrangements for obtaining the required supplemental care or services from a civilian source. This will require the use of Naval Hospital operation and maintenance funds. The requesting physician must obtain prior approval from the Commanding Officer or their designee in order to prevent unauthorized commitment.

b. Supplemental Care or services authorized

(1) All specialty consultations for the purpose of establishing or confirming diagnoses or recommending a course of treatment.

(2) All diagnostic tests, diagnostic examinations, and diagnostic procedures, such as genetic tests, CAT scans, etc.

(3) Civilian ambulance service ordered by a military physician to transport the patient from this facility to another medical facility.

c. Action

(1) The attending physician shall complete the Referral for Civilian Medical Care (DD-2161), with an estimated cost of service prior to directing patients for any nongovernment services.

(2) After approval is received, a copy of the original DD-2161 is provided to the patient to take to his appointment. The original DD-2161 is to be forwarded to the HBA and Head, Fiscal Department. After normal working hours, emergent referrals must be approved by the OOD.

(3) Failure to comply with these procedures constitutes an unauthorized commitment. As such, the requesting physician is liable for all costs incurred for the requested services.

(4) All personnel are advised that directing patients to acquire services without the Commanding Officer's approval and funding authorization will result in a personal financial liability on the part of the requester, not the government.

(3) Civilian ambulance service ordered by a military physician to transport the patient from this facility to another medical facility.

c. Action

(1) The attending physician shall complete the Referral for Civilian Medical Care (DD-2161), with an estimated cost of service prior to directing patients for any nongovernment services.

(2) After approval is received, a copy of the original DD-2161 is provided to the patient to take to his appointment. The original DD-2161 is to be forwarded to the HBA and Head, Fiscal Department. After normal working hours, emergent referrals must be approved by the OOD.

(3) Failure to comply with these procedures constitutes an unauthorized commitment. As such, the requesting physician is liable for all costs incurred for the requested services.

(4) All personnel are advised that directing patients to acquire services without the Commanding Officer's approval and funding authorization will result in a personal financial liability on the part of the requester, not the government.

CHAPTER 6

OUTPATIENT MEDICAL RECORDS

6-1. Purpose. To set forth policy and procedures for the transfer, loan and release of outpatient medical records in accordance with references (b) and (j).

6-2. Policy. Naval Hospital, Twentynine Palms, will maintain a medical record system that permits prompt retrieval of information. Medical records maintained by Naval Hospital are property of the U.S. Government. Medical records must be legible, documented accurately, filed timely, and be readily accessible to healthcare providers. Information in the records of individuals who have received medical examination, care and treatment, is personal to the individual and therefore considered privileged. Accordingly, medical treatment records shall not be released to any person or organization in a manner that will compromise the individual's interest or the Federal Government's interest and custody. Information contained in patients' records shall be safeguarded against loss, defacement, tampering or use by unauthorized persons. All medical records shall be specifically handled to prevent loss or misplacement and assure that there is no release of information that might violate the patient's interest or be detrimental to their health.

6-3. Privacy Act Requirements. Certain information is necessary to provide, plan, and coordinate healthcare. The information provided, as with the patient's entire record, is considered private and will not be given out without the written consent of the patient or in the case of minors, their parent or legal guardian. A copy of the Privacy Act Statement (DD-2005), will be explained to and signed by the patient or their sponsor. The signed statement will be entered as a permanent part of the patient's record. The DD-2005 is not a consent form to release or use healthcare information.

6-4. Requests for Release of Medical Records. During working hours, requests for outpatient records, or information contained therein, will be forwarded to the Outpatient Records Office for action. After working hours, outpatient records, or information contained therein, will not be released to any non-hospital staff person without the prior approval of the Head, Patient Administration.

a. Handcarrying treatment records by the patient is to be minimized. Hospital staff will make every effort to transfer needed records directly to the clinic or treatment facility. The transfer of outpatient records, except specialty records (ie: OB, COLPO, Mental Health), immunization appointments, and same day appointments, will be processed by the Outpatient Records Office. In all cases, the Outpatient Records Release Request (NAVMED 6150/8) will be completed.

(1) Appointments at Other Treatment Facilities

(a) Original outpatient records are the property of the government and shall not be released for transfer to civilian treatment facilities. Patients with appointments at civilian facilities may obtain a copy of the health record when requested 72 hours in advance, with the exception of emergencies.

(b) Original outpatient records may be released for transfer to other military treatment facilities provided a NAVMED 6150/8 is completed. The patient must be advised to return the record to the proper primary medical treatment facility.

(2) Patients may obtain copies of excerpts from their health record when they have conditions which necessitate continuing care while vacationing.

(3) Release of Records to Spouse. To ensure the privacy of records is maintained, written consent from the patient must be submitted prior to the release of the health record or its contents. A completed NAVMED 6150/8 will suffice.

(4) Records with Restricted Status. If a medical record has been placed in a restricted status, only hospital staff will be allowed to handcarry the record to the necessary clinic. The patient or guardian may view the record in the presence of hospital staff. Excerpts from the record may be copied.

b. Records Requested by the Emergency Room. When required, Emergency Room staff will notify Outpatient Records staff of the need for an outpatient record. The outpatient record will be pulled from the file for retrieval by Emergency Room staff. After normal working hours, a general duty watchstander may be used to handcarry records to the Emergency Room.

c. Request for Records from Civilian Hospitals, Clinics, or Other Non-Federal Providers. Record requests must be accompanied by a statement, signed by the individual, or guardian, whose record is requested, authorizing the release of said record. The original record will remain and a copy of the record forwarded as requested. There is no fee charged for copying records necessary for continuation of medical care.

d. Request for Records from Insurance Companies and other Private Agencies. Requests will be processed in the same manner as requests from private providers except a minimal charge will be assessed per reference (r) for copying records.

e. Request for Excerpts of Records. When considered essential, copies of excerpts of records may be provided to patients upon proper completion of a NAVMED 6150/8.

6-5. Requests for Transfer of Medical Records

a. Requests from Patients or Guardians. Treatment records shall be permanently transferred only upon a change of residence of the sponsor or patient. Records may be transferred upon written notification of transfer. A properly completed Request for Medical/Dental Records (DD-877) will suffice. Medical records will normally be transferred by mail, requests to handcarry records can be approved when a properly completed NAVMED 6150/8 is submitted. Records to be handcarried will be sealed in an envelop to ensure integrity.

b. Requests from Other Military Treatment Facilities. Outpatient records may be transferred, by mail, to other military treatment facilities when properly requested in writing or completed DD-877.

c. Requests from Civilian Facilities. Medical records are the property of the U.S. Government and will not be transferred to civilian facilities.

6-6. Security of Records. Outpatient records must be safeguarded to ensure record integrity and prevent improper release of private information protected by law. During normal operating hours, the Patient Administration Department will maintain at least one staff member in the Outpatient Records Office to process medical record requests. After normal working hours, the Outpatient Records Office must be locked. Access to records after working hours must be authorized by the Officer of the Day.

CHAPTER 7

PROCESSING EMERGENCY CARE AND TREATMENT RECORDS

7-1. Background. In accordance with references (a), (b), (j) and (s) precise documentation and maintenance of accurate records of emergency care provide the primary data source for continued medical care, quality assurance, official audits, and possible litigation. It is essential, therefore, that effective mechanisms for completing emergency treatment records and maintaining of file copies of these records be implemented throughout the command when providing emergency services.

7-2. Action

a. Patients presenting for emergency treatment shall be checked in at the reception desk using the Automated Quality of Care Evaluation Support System (AQCESS) computer system. The patient's log number will automatically be assigned by the AQCESS system and will change each day at midnight.

b. An Emergency Care and Treatment record (SF-558) shall be completed by the attending medical officer following the guidance provided below:

(1) Non-compliance. If a patient refuses to sign the discharge instructions, declines to follow medical instructions, or leaves the Emergency Room against the provider's advice, the facts and circumstances of the situation shall be documented in the History and Physician's block. In addition, an Against Medical Advice Form (NH29PALMS 6320/71) must be completed and attached to the SF-558. The Officer of the Day will be immediately notified of any of the above mentioned situations.

(2) Transfers. When a patient is transferred to another hospital after being treated in the Emergency Room, the "referred to" block will be completed, stating where the patient was transferred and who the accepting physician was.

(3) Provider's Signature. Charts of patients seen by a non-physician must be co-signed by the staff medical officer who is fully responsible for care provided during their watch. This block must also include the provider's stamp.

(4) Patient Instructions. The "Patient Instructions" block must be thoroughly completed by the care provider and will include instructions on medications prescribed, where and when follow up care is to be sought and any instructions specific to

the patient's condition. If a separate instruction sheet is provided to the original SF-558 and filed in the treatment record (i.e., head trauma sheet), the "Patient Instructions" block should indicate the name of the treatment sheet. If the patient is transferred or admitted to the hospital, the patient's instruction block should be marked "non-applicable (N/A)."

(5) Log Number. Enter the number assigned to the patient on the Emergency Room Log. The Emergency Room Log shall be compiled in monthly binders.

(6) Continuation Notes. In the event that additional space is required, a second dated SF-558 will be addressographed and marked in the history and physical block "Continuation Notes." The disposition and treatment blocks will be completed on the first form only.

(7) Time of Release. This block must be completed by the Emergency Medicine Department staff and is a critical element in the continuing evaluation of quality of care.

c. Emergency Room Nurse's Assessment and Notes shall be completed in accordance with the guidance provided in the Departmental Policy and Procedure Manual. This includes critical patients and those requiring frequent monitoring by nursing service staff.

d. The original Emergency Treatment Record shall be filed in the patient's outpatient chart. The first copy shall be compiled chronologically in a daily binder and maintained on file within the Emergency Medicine Department. The second copy shall be given to the patient as a written recommendation of treatment and follow-up.

e. The Emergency Medicine Department shall maintain the check-in log for a period of two months. Daily binders of the SF-558s shall be maintained for a two year period. Records prior to that date are kept in departmental archives.

7-3. Quality Assurance

a. All Emergency Treatment Records of patients seen by non-physicians shall be reviewed by a medical officer. A record of discrepancies shall be maintained and summary included in the monthly minutes of the Emergency Room departmental minutes.

CHAPTER 8

PATIENT'S PERSONAL EFFECTS AND VALUABLES

8-1. Purpose. To set forth policies and procedures on managing and controlling the depositing, handling, safekeeping, withdrawing, and disposing of patients' personal effects and valuables, pursuant to references (j) and (t).

8-2. Definitions

a. Valuables. Monies, jewelry, negotiable instruments such as: bonds; traveler's checks; credit cards; money orders; checks and bank drafts; and other items of intrinsic value.

b. Personal Effects. Patient possessions other than valuables, such as: wallets; identification cards; keys; clothing and baggage.

8-3. Action

a. Patient Valuables

(1) The Head, Patient Administration Department shall:

(a) Be appointed as the Patient Valuables Primary Custodian.

(b) Assume responsibility for the acceptance, safekeeping and accounting of the patient's valuables.

(c) Ensure Officer of the Day and Mate of the Day watchstanders are aware of proper patient valuables procedures to ensure compliance with this instruction.

(d) Ensure there is an adequate supply of NAVMED 6010/9s in the Emergency Room and on the wards.

(2) The Officer of the Day (OOD) shall receive and maintain custody of patient valuables after normal working hours. OODs shall be totally familiar with this instruction in fulfilling this duty. They shall log the NAVMED 6010/9 into the valuables log book and drop the 6010/9 into the drop box.

(3) Staff who provide pre-admission counseling are responsible for advising patients not to bring valuables to the hospital.

(4) The Emergency Department Nurse shall make a special notation on the Emergency Treatment Record when any personal effects or valuables are received from patients treated in the Emergency Room.

(5) The Ward Nurse shall ensure that patients are informed of the importance of depositing valuables for safe keeping and shall deposit those valuables for patients who are incapacitated.

(6) Head, Patient Valuables Audit Board, shall submit monthly, in writing, the results of the Board's audit to the Commanding Officer via the Chairman, Command Audit Boards.

b. Personal Effects

(1) Emergency Department staff shall inventory, bag, tag, and deliver personal effects to the ward nurse when a patient is admitted. A tag shall be affixed to the outside of the bag listing the patient's name, rank, social security number, and date. Inventorying and tagging shall also apply when a patient is transferred to another medical facility.

(2) The Ward Nurse shall receive the personal effects and store them in a safe area on the ward. Bedside lockers may be used if space permits. Larger or high value items may be brought to the Patient Administration Department for storage and safe keeping. When a patient is discharged or transferred from the ward, the ward nurse shall ensure that all personal effects accompany the patient.

(3) Ambulance attendant personnel shall receive the personal effects of patients being transferred to other medical treatments facilities and are responsible for ensuring delivery to the accepting medical facility.

c. Weapons. Patient weapons shall be delivered to the Master-At-Arms office for turn over to PMO. After normal working hours, the OOD shall maintain temporary custody of weapons pending forwarding to Military Police or the patient when the patient is not admitted.

d. Patient's Valuables

(1) <u>Inventories</u>. Inventories shall be conducted prior to deposit. Inventories are conducted by two persons. In cases where the patient is a commissioned officer, inventories shall be conducted and witnessed by commissioned officers. If the patient

is enlisted or a supernumerary, the inventory may be conducted and witnessed by either a commissioned officer or an enlisted staff member. A civilian registered nurse may act in the place of a commissioned officer. Inventories shall be recorded on the Patient Valuables Envelope (NAVMED 6010/9) and the valuables shall be placed in the NAVMED 6010/9. The Primary or Alternate Patient Valuables Custodian shall not conduct or witness inventories of patient valuables.

(a) Part A. Identification of Patient.

(b) Part B. Inventory of Valuables Deposited. When describing jewelry, use yellow or white metal instead of gold or silver as color descriptions. Non-applicable areas should be indicated as such.

(c) Part C. Certification of Receipt. Personnel conducting the inventory will complete the first two sections of this part, the Valuables Custodian will complete the acceptance for deposit section.

(2) Deposits. When valuables are to be deposited, personnel authorized to receive the deposit shall:

(a) During Normal Working Hours. Document the acceptance of deposit on the NAVMED 6010/9, provide the delivery officer with green and pink copies of the NAVMED 6010/9, (the green copy is to be retained by the delivery officer and the pink copy is to be returned to the patient), make the appropriate patient's valuables logbook entry, and deposit the valuables in the safe.

(b) After Normal Working Hours. Document the acceptance of deposit on the NAVMED 6010/9 by initialing next to the Custodian's signature block, provide the delivery officer with green and pink copies of the NAVMED 6010/9, make the appropriate dropbox logbook entry, and deposit the valuables in the patient's valuables drop box located at the Information Desk. Patient Valuables Custodian will inventory and transfer the patient's valuables to the safe on the next normal work day.

(3) Withdrawals. Partial withdrawals are not authorized. Redeposits may be authorized only once during a single inpatient stay. Long term patients shall be encouraged to use available banking facilities. Procedures for withdrawals are:

(a) During Normal Working Hours. The patient shall present the pink copy of the NAVMED 6010/9 to the Patient Valuables Custodian upon verification of the patient's identity, the patient will be given his/her valuables and be required to sign the file (white) copy of the NAVMED 6010/9.

(b) Weekends and Holidays. Patients scheduled for discharge on weekends or holidays should be strongly encouraged to arrange to withdraw their valuables from the Patient Valuables Custodian during normal working hours. Valuables will not be released after normal work hours and only on weekends on a case-by-case basis.

(c) By Persons Other Than The Patient. The withdrawal of patients valuables or personal effects may be made by an authorized representative of the patient, or Federal Investigative Agencies. Authorization must be in writing and shall normally be on the back-side of the pink copy of the NAVMED 6010/9. Authorization shall state, by name, the individual being authorized to withdraw the valuables and be signed and dated by the patient.

e. Deceased Persons. Valuables shall not be removed from a deceased person without the approval of the County Coroner's Office. Once removed, valuables will be inventoried and processed as outlined above. If heirs or next of kin are present, the patient's valuables may be given to them and a receipt obtained utilizing the NAVMED 6010/9. In a Coroner's case, the valuables should be released to the Coroner and a receipt obtained.

f. Incapacitation

(1) Transactions concerning the deposit and withdrawal of personal effects or valuables of patients physically or mentally incapacitated shall be delivered to the Patient Valuables Custodian. The following signature guideline shall be used: "I. M. BOSS, LT, MSC, USNR, OOD, for John D. Patient who is unable to sign".

(2) Records of all transactions on behalf of incapacitated patients shall be maintained by the Patient Valuables Custodian.

8-4. Loss and Audit Control

a. Loss Control. The after hours drop box shall be located at the Information Desk that is manned 24 hours daily. The box shall be secured with two padlocks. A key to one padlock shall be maintained by the OOD. A key to the other padlock shall be maintained by the nurse assigned to narcotics control on the ward. The presence of both officers is required to open the drop box. The Patient Valuables Custodian also has access to the drop box contents.

b. Audit Control. The Patient Valuables Audit Board shall conduct a verification of patient valuables held for deposit at monthly intervals. Discrepancies in the safekeeping of deposits shall be reported to the Commanding Officer for further action and investigation as deemed necessary. In cases of lost personal effects or valuables, the patient shall be directed to the Head, Operating Management Department, where a claim may be submitted for reimbursement.

8-5. Procedures for Patient Valuables Audit Board's Audit of Patient Valuables

a. The Patient Valuables Custodian shall be audited by Naval Hospital Patient Valuables Audit Sub-Board on a monthly, unannounced basis.

b. The purpose of the audit is as follows:

(1) Determine if the contents of patient valuables envelopes agrees with the information listed on the outside of the NAVMED 6010/9.

(2) Determine if the contents of the Patient Valuables safe agree with the Patient Valuables Log Book.

c. In order to complete the audit, the Audit Team in the presence of the Patient Valuables Custodian shall:

(1) Ensure that all NAVMED 6010/9s are fastened and taped with the Patient Valuables Custodian, initials superimposed over the tape.

(2) If there is a suspicion of tampering or other unusual circumstance, unfasten the NAVMED 6010/9 and check its content against the listed contents. After verifying the contents of the NAVMED 6010/9, the auditor shall refasten and retape the envelope, superimposing their signature over the tape.

(3) Ensure that the Patient Valuable Log Book is current by:

(a) Ensuring there is a retained white copy of the NAVMED 6010/9 for all numbers which the log indicates were checked out.

(b) Ensuring that all retained white copies of the NAVMED 6010/9 have the signature of the patient or indication that the valuables were picked up by a person authorized to act for the patient. The pink copy of the NAVMED 6010/9 or other documentation recording the authorization for valuables pickup by an agent of the patient shall be attached to the white copy.

(c) Ensuring that all NAVMED 6010/9s that are not checked out are within the safe.

(4) Ensure that timely efforts are made to dispose of unclaimed or abandoned patient valuables.

CHAPTER 9

SERIOUS AND VERY SERIOUS LIST

9-1. Purpose. To publish local policies and procedures to be followed when either placing patients on or removing them from the Serious List or Very Serious List (SL/VSL) and to emphasize procedures to be followed for the expeditious notification of the next of kin.

9-2. Background. Navy Department policy pertaining to the notification of the next of kin (NOK) of seriously and very seriously ill or injured patients requires strict adherence. In keeping with humane practices toward the patients' NOK, references (u) and (v) set the protocol for effecting notification and the submission of routine progress reports.

9-3. Definitions

a. Seriously Ill or Injured. A patient whose illness or injury is of such severity to cause immediate concern but not imminent danger to life. Further, when it is determined that an active duty member is suffering from an incurable (terminal) illness, he shall be placed on the "Serious List", even though there appears to be no immediate threat to life.

b. Very Seriously Ill or Injured. A patient whose illness or injury is of such severity that there is threat of imminent loss of life.

c. Next of Kin (NOK). The next of kin is always the spouse, if married. If unmarried, the NOK is usually the mother. When in doubt, verify with the Patient Administration Department. In cases of children of active duty members, the active duty sponsor is the NOK, who must be notified, especially if the active duty member is deployed.

9-4. Action

a. Medical Officer shall:

(1) Place on and remove patients from the SL/VSL by making an appropriate entry in the doctor's orders.

(2) Promptly complete and sign the Serious/Very Serious Condition or Death of Patient on Ward (NAVMED 6320/5). The diagnosis recorded on the form shall be the diagnosis for which the patient was placed on or removed from the list, not necessarily the admission diagnosis.

(3) Notify the Medical or Surgical Director.

(4) Notify the NOK in strict compliance with the following procedures:

(a) If the NOK is present, make personal notification in all cases; including the patient's present condition and, if the NOK asks, prognosis.

(b) If NOK is not present, make notification via telephone except when the patient is an active duty Marine Corps member. Notification to NOK in the case of active duty Marines is the responsibility of the member's parent unit.

(5) If notifying the NOK via telephone, the medical officer will ensure that prompt notification is made. If, after several attempts, the medical officer is unable to contact the NOK, notification may be made by the Patient Administration Department or Officer of the Day.

b. Nursing Services personnel shall:

(1) Immediately prepare (in triplicate) the patient data portion of the NAVMED 6320/5. After the medical officer's review and signing, hand deliver the original to the Patient Administration Department. Place one copy in the patient's record and deliver the other copy to the OOD's Desk.

(2) Promptly notify the Patient Administration Department via telephone of the placement or removal of patients on the SL/VSL. Telephone notification does not substitute for the preparation and submission of the NAVMED 6320/5.

c. Head, Patient Administration Department shall:

(1) Ensure the OOD has been notified so that an appropriate entry can be entered into the Command Journal.

(2) During normal working hours, notify the Commanding Officer of all changes to the SL/VSL.

(3) Make notification to the NOK by telegram only if the medical officer is unsuccessful in contacting the NOK. After normal working hours, the OOD will make telegram notification.

(4) Effecting notification for active duty Marine Corps members through the appropriate Marine Corps District. The Director, Twelfth Marine Corps District shall be notified by phone when a Marine is placed on the SL/VSL. Concurrently, the member's parent command shall be notified via telephone, if aboard the Marine Corps Air Ground Combat Center, Twentynine Palms. Sufficient information will be given to effect notification and followÄup procedures. The District Director will inform Patient Administration Department after personal notification of the primary NOK has been completed. The OOD shall then release a confirming message to the primary NOK.

(5) Preparation and publication of a daily SL/VSL when necessary.

d. Submission of a Personnel Casualty Report is the responsibility of the member's parent unit. If the member's unit is unavailable or unknown, initial reporting may be made by this command.

9-5. Miscellaneous

a. The procedures for removing patients from the SL/VSL shall be the same as those placing patient on the list.

b. All areas of responsibility in this instruction which are assigned to the Patient Administration Department shall become the responsibility of the OOD after normal working hours. Therefore, any notification made by the medical officer or ward nurse after normal working hours shall be directed to the Information Desk.

9-6. Baptism of Infants on the SL/VSL

a. Baptism of infants on the very sick list is mandatory by certain religious groups. Conversely, there are other groups who do not sanction it.

b. The following procedure will be followed in all applicable cases:

(1) Ascertain the faith of the child's parents from NAVMED 6300/5, or other reliable source.

(2) In view of the fact that some religious denominations do not practice infant baptism, caution and meticulous effort should be exercised to obtain the express consent of the parents.

(3) If the parents desire baptism for the child, the Religious Program Directorate Office (duty chaplain after hours) should be notified who will in turn contact the appropriate chaplain. Because of the diversity of religious belief and practice, the Religious Program Directorate should be notified as soon as possible.

(4) If the parents are Catholic and the death of the infant is imminent, anyone may perform baptism by pouring clear water upon the head and repeating, "I baptize you in the name of the Father, and of the Son, and of the Holy Spirit". The person must merely have the intention of the Church. This same procedure may be followed when the parents are Protestant and request baptism.

CHAPTER 10

DECEDENT AFFAIRS PROGRAM

10-1. Scope. This guidance applies to all deaths occurring at Naval Hospital, Twentynine Palms, the Marine Corps Air Ground Combat Center (MCAGCC) and of Navy and Marine Corps personnel occurring off-base within this command's administrative responsibility for disposition of remains.

10-2. Background. Reference (v) identifies guidelines and specific responsibilities for the implementation of the Decedent Affairs Program (DAP).

10-3. Action

a. Head, Patient Administration Department is assigned collateral duty as the Decedent Affairs Officer. Reference (v) provides guidance for all activities within the Decedent Affair Program (DAP). After normal working hours, the OOD will assume these responsibilities.

b. The Medical Officer in immediate attendance shall:

(1) Render the official pronouncement of death. If a Medical Officer is not in immediate attendance, the first Medical Officer arriving on the scene shall perform this duty.

(2) Prepare a NAVMED 6320/5, in duplicate, and ensure delivery of the original during normal working hours to the Decedent Affairs Officer with a copy to be delivered to the Information Desk. After normal working hours, deliver the original and copy to the Information Desk.

(3) If the next of kin (NOK) is present, the Medical Officer shall make personal notification and inform the NOK of probable or known cause of death and any other information that the Medical Officer may deem appropriate or prudent.

(4) Furnish the Decedent Affairs Officer (or his representative) with sufficient information to complete the California State Certification of Death. Required information includes cause of death, significant conditions and interval between onset and death. The Medical Officer shall be available to sign the certificate after it has been typed.

c. Nursing Services Personnel shall:

(1) Immediately notify the Officer of the Day of the death. Notify the Information Desk of the request for a Duty Chaplain. Notification of the Chaplain shall be recorded in the appropriate block on the NAVMED 6320/5.

(2) Ensure that the remains have been properly prepared prior to transfer of remains to the morgue. Preparation shall be as follows:

(a) Place a screen around the patient so other patients will not be disturbed.

(b) Close eyes, replace dentures and any other prosthetic devices.

(c) Only after permission is received from the County Coroner, change the dressing, remove any drainage tubes, and close draining wounds with adhesive tape.

(d) Bathe the body if necessary.

(e) Prepare identification tags containing the following information: name, social security number, status, diagnosis, ward, date and time of death, and the name of the Medical Officer pronouncing death. Tagging shall be as follows:

1 Tie one tag to the left great toe (ankle on infant).

2 Tie one tag to the right wrist.

(f) Place arms over chest; place clean sheet diagonally under body. Fold upper corners over head, lower corners over feet, bring sides over to completely cover the body. Secure the sheet with safety pins and pin a third identification tag to the outside of the sheet.

(g) Inventory and itemize the deceased's personal effects as described in Chapter 8.

(h) Upon approval from the San Bernardino County Coroner's Office, transfer the body to the morgue.

d. Nursery Staff shall ensure that:

(1) Procedures for preparation of fetal demise births or deaths of newborn babies shall be the same as for an adult, except that the tag shall be attached to the ankle. The body weight in grams shall be included on the tags.

(2) If an autopsy is requested by the medical officer, the remains will normally be transferred to Naval Hospital, Camp Pendleton, only after the County Coroner has released the remains. The following paperwork should accompany the remains:

(a) Copy of mother's Clinical and Outpatient chart and any records on the baby.

(b) Autopsy Authorization (SF-523), original and two copies, signed by the parent(s) and witness.

(c) Receipt of Remains Form (original and one copy).

1 Original signed and witnessed, shall be brought back as file copy for remains delivered.

2 Copy shall be retained by receiving hospital or morgue.

e. Decedent Affairs Officer shall:

(1) Ensure that all necessary preparations of the remains have been completed prior to accepting the remains.

(2) Upon discharge from the morgue, ensure that the remains are logged out in the Morgue Log and that all accompanying paperwork is released.

f. Officer of the Day shall:

(1) After normal working hours, accomplish proper notification of cognizant authorities, using the Decedent Affairs Check-off List contained in Appendix K.

(2) Notify the Head, Patient Administration Department of the death so that proper administrative guidance can be provided.

(3) Notify the Decedent Affairs Officer when remains are to be released so that he can provide administrative assistance.

10-4. Location of Prepared Death Packages. Prepared "Death Packages" will be kept in adequate quantity and shall contain all necessary forms and instructions. These packages will be located at the Information Desk.

10-5. Miscellaneous. In no instance will the remains of a deceased person be moved, nor will any tubes, catheters, airways, etc., be removed until permission is granted by the County Coroner. Additionally, if an autopsy is ordered or requested, the remains will be treated with utmost care so as not to cause any additional marks or bruises on the body.

10-6. Notification of the County Coroner

a. In accordance with reference (w), the Coroner must be notified of the following types of death:

(1) Without medical attendance (includes dead on arrival);

(2) During the continued absence of the attending physician (not within the period of ten days prior to death);

(3) Where the attending physician is unable to state the cause of death (without an autopsy);

(4) Where suicide is suspected;

(5) Following an injury or accident, or

(6) Under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another."

b. The OOD or Decedent Affairs Officer, as appropriate, will notify the County Coroner in all cases of death.

10-7. Next of Kin Notification of Deaths. Notification may only be made after positive identification of the remains.

a. Next of Kin not Present. Notification of NOK is the responsibility of the deceased member's parent command. In the case of non-active duty member's notification is the responsibility of the San Bernardino County Coroner's Office.

b. Next of Kin Present. The medical officer pronouncing death will inform the NOK. Presence of the duty chaplain is encouraged.

10-8. Care of the Dead Responsibilities

a. In the case of Marine Corps active duty deaths, the unit is responsible for procuring the following:

(1) Clothing for the remains (dress blues, to include the cover, gloves, socks, shoes, insignias, badges, white belt, under shirt, and shorts)

(2) Select the escort.

b. Decedent Affairs Officer is responsible for the following:

(1) Provide the flag(s).

(2) Instruct the escort as to his duties.

(3) Ensure the completion of the California Certificate of Death.

(4) Make preliminary and final inspection of the remains.

(5) Release and make shipping arrangements for the remains.

(6) Coordinate with the assigned Casualty Assistance Calls Officer (CACO).

(7) Render such assistance to the NOK as deemed humane and prudent under the circumstances.

10-9. Autopsies

a. In the event of death of active duty personnel at this hospital under unnatural or suspicious circumstances when there is reason to believe that the cause of death might constitute a public health menace or when the cause of death is unknown, the attending medical officer shall recommend to the Commanding Officer that an autopsy be performed to determine the cause of death. Such authorization shall be completed on a SF-523.

b. In all other circumstances, when an autopsy is deemed necessary of retired or non-military personnel, written authorization from the NOK must be obtained before the autopsy is performed. When the authorization is obtained by letter, telegram, or voice recording or monitored telephone call, a

SF-523 shall be completed with the authorization attached. If permission is unobtainable, and an autopsy is required to complete records of death in compliance with local, state or federal law, a report shall be made to civil authorities for necessary action.

CHAPTER 11

CENTRAL APPOINTMENT SYSTEM

11-1. Purpose. To provide guidelines and objectives toward the development of a more responsive patient appointment system at Naval Hospital, Twentynine Palms.

11-2. Background. In order to enhance patient satisfaction, workload distribution, and to ensure maximum use of healthcare providers' time, outpatient appointments are scheduled through a central office and within major clinics. To further enhance the efficiency of scheduling, the Appointing and Scheduling function of the Automated Quality of Care Evaluation Support System (AQCESS) has replaced manual scheduling methods.

11-3. Policy and Procedures

a. Customer service hours of the Central Appointment Office are from 0730 Ä 1530. SameÄDay appointments are reserved for those patients with acute medical conditions that should be seen promptly but do not meet the criteria for use of the Emergency Room.

b. Specific Clinics and Emergency Room FollowÄup Appointments will be scheduled by the Central Appointment Office. Patients requiring followÄup appointments that exceed the schedule currently in the computers will be placed on a waiting list and will have their appointments scheduled automatically prior to the time that the attending physician has specified. Clinic templates shall ensure adequate availability for follow up appointments. Appointments that are not booked prior to distribution of the daily provider appointment schedule should be converted to Same Day Appointments.

c. To allow time for patient registration, taking of vital signs, etc., patients' will be instructed to report to the clinic 15 minutes prior to their appointment.

d. Cancellation of appointments by clinic personnel will be done on a case-by-case basis. When cancellations occur, efforts will be made to spread patient load over remaining physicians' schedules rather than deferring the patient's visit to the next available appointment time.

(1) Department Heads shall submit cancellation notices to the Head, Patient Administration via the Director of Medical Services or Director of Surgical Services in the form of a memorandum. If notification is not received five (5) working days in advance, it will be the responsibility of the individual clinic to assist with notifying patients of the cancellation.

(2) Cancellation of appointments, due to emergency situations requiring the absence of the physicians, may be referred to the Appointment Office Supervisor for rescheduling.

11-4. Action

a. Heads of Clinical Departments shall:

(1) Review all clinic schedules prepared by the Schedule Coordinator prior to submission to the Director of Medical Services or Director of Surgical Services.

(2) Ensure that the Schedule Coordinator is fully aware of any leave, temporary assignment of duty (TAD), conferences, meetings, etc., for clinic physicians that would affect the schedule.

(3) Establish procedures to ensure that patients are kept informed on waiting times.

(4) Establish procedures to ensure that patients are given specific instructions for followÄup appointments.

b. Schedule Coordinator shall:

(1) Ensure that Supervisor, Central Appointment Office is provided copy of clinic schedule for input with an eight (8) week proposed schedule to be submitted by the end of the first full week of the month preceding the scheduled period.

(2) Ensure that clinic templates are continuously reviewed to ensure maximum access to care while maintaining optimal quality of care.

c. Head, Patient Administration Department shall:

(1) Ensure that Central Appointment Office personnel conduct eligibility checks on all patients seeking care through the Central Appointment System.

(2) Ensure that the Central Appointment Office provides the clinics with computer printout of appointment roster for each physician, clinic office, and a Consolidated Records Pull List for the Outpatient Records Section by 1515 of the previous working day.

(3) Establish procedures and controls to ensure that all follow up patient appointments are scheduled as directed by the physician and that the patients are effectively notified.

d. Medical Staff shall:

(1) Keep, the Schedule Coordinator, Department Head, Head, Patient Administration, and Supervisor, Central Appointment Office adequately informed of required changes to individual schedules to ensure that patients are rescheduled promptly.

(2) In the event that a high risk patient misses an appointment that may be hazardous to their health, the physician shall ensure that the patient is called and advised. If the patient cannot be reached by telephone, the clinical department should then refer the patient's name, address, and telephone number to the Head, Patient Administration Department who will attempt to contact by whatever means is deemed appropriate, i.e., telephone or letter.

CHAPTER 12

FAILURE TO APPEAR FOR MEDICAL APPOINTMENTS

12-1. Purpose. To establish policy and procedures for addressing patients who fail to appear for scheduled medical appointments or cancel scheduled appointments in a timely manner.

12-2. Background. The Naval Hospital has a very limited number of providers to provide timely medical care to the total patient population. When the already over-taxed medical system is complicated by patient failure to show for scheduled appointments, it deprives other patients from receiving medical care.

12-3. Policy. It is the policy of this activity that medical appointments be made available to the maximum number of patients and that corrective action be initiated with patients who misuse the appointment system.

12-4. Definitions. An appointment shall be considered to have been missed when one of the following occurs:

a. No Show. The patient fails to appear for the appointment.

b. No Cancellation. The patient cancels the appointment less than 60 minutes prior to the scheduled appointment time.

12-5. Action

a. Clinical Department Heads shall:

(1) Notify the Head, Patient Administration Department, in writing, of supernumerary patients who fail to show or cancel appointments.

(2) Ensure that an entry is made on a Chronological Record of Medical Care (SF-600) in the patient's medical record, indicating that the appointment was missed. The entry shall be made in red ink with a stamp similar to the following:

NO SHOW/NO CANCEL

DATE: _____ TIME: _____

DOCTOR: _____ CLINIC: _____

b. Head, Military Sickcall Department shall:

(1) Upon notification of an active duty patient assigned to Headquarters, Marine Corps Air Ground Combat Center or Marine Corps Communication and Electronics School, who fails to show or cancel an appointment, ensure that an entry is made in the health record as described in paragraph 12-5a(2) above.

(2) Notify the Head, Patient Administration Department, in writing, of patients who fail to show or cancel appointments.

c. Head, Management Information Department shall provide the Head, Military Sickcall Department with a biweekly listing of active duty patients assigned to Headquarters, Marine Corps Air Ground Combat Center and the Marine Corps Communications and Electronics School, who fail to show or cancel appointments under the Ambulatory Nursing Department's cognizance.

d. Head, Patient Administration Department shall upon receipt of notification of a non-compliant patient, prepare and mail Appendices (L), (M), or (N) as appropriate.

e. Healthcare providers shall review the no show health record to determine if the patient is a high risk patient. The Director Medical Services or Director Surgical Services will be notified, immediately, of no shows who are determined to be high risk patients.

CHAPTER 13

RELEASE OF INFANTS TO OTHER THAN PARENTS THROUGH ADOPTION

13-1. Policy. Staff members should be made aware of the concern of the Department of the Navy in high risk family situations. This command is not an adoption agency and it should not be placed in a position by actions of staff members which could be perceived as a promoter of adoption agencies. Preliminary adoption procedures, however, should be instituted by pre-natal parents who wish to place their infants for adoption following birth in this facility. The request can be made by either or both parents and the following procedures shall be followed.

13-2. Action

a. Release through Authorized Adoption Agencies

(1) A mother desiring to place her infant for adoption shall be directed to deal directly with the state or county agency involved. An expectant mother will be required to sign forms of the agency with which the infant is to be placed. This includes the Infant Release of Information Authorization(State of California Form), which shall be prepared by the Patient Administration Department.

(2) A representative of the Patient Administration Department and the representative of the agency will obtain the infant from the Nursery and leave an authorization signed by the mother for the release of the infant to the agency. This State of California Form will become a part of the infants inpatient record. A transcript of the medical records or such information as required by the agency will be released with the infant.

(3) The exchange process cannot be accomplished on weekends as neither the Patient Administration Department nor adoption agency personnel are available. Therefore, should the infant be ready for discharge during the weekend, the infant's inpatient care must be extended until the Patient Administration Department representative and the adoption agency representative are available to complete the exchange procedure. The mother desiring to place her infant may be discharged when ready, regardless of whether the weekend is involved, provided she has completed all necessary forms to complete the exchange and placement for adoption.

b. Release through Private Adoption Agencies

(1) When one or both parents desire to make independent adoption plans, the mother or the legal father will be required to take the infant from the hospital as routine discharge of the mother and infant. This command will not become involved in release to other than the parents or parent in such cases.

c. Release of an infant to Child Protective Services(CPS)

(1) If the well-being of a newborn is in question, for example, if it has been exposed to drugs, the Medical Officer shall contact the Family Advocacy Representative (FAR) in accordance with reference (x). The FAR will contact the appropriate agencies. If deemed necessary, the Naval Hospital will release the newborn to the Naval Investigative Service (NIS) which will further release the newborn to CPS upon discharge.

(2) The Nursery shall notify the Head, Patient Administration during normal working hours or the OOD after normal working hours to inform that a newborn is to be released to CPS.

(3) The OOD shall document the discharge in the Command Journal.

(4) Parental consent is not necessary to release the child to Child Protective Services.

13-3. Payment. A mother placing her child for adoption will be required to make arrangements in advance for payment of hospitalization for herself and the infant.

13-4. Availability of Forms and Reports. The Release of Information Authorization will be typed by the Patient Administration Department as required. Forms required by the adoption agency will be provided by the agency. Hospital Infant Release Report (State of California Form) will be completed and submitted by the Patient Administration Department as required.

13-5. Instructions for Use of the Infant Release Report

a. The Infant Release Report is the parent's authorization for a child to be removed from the hospital by a non-related person. The form should be prepared in duplicate. The original is to be forwarded within 48 hours after removal of the child from the hospital to the Bureau of Adoptions, State Department of

Social Department of Social Welfare, 722 Capitol Avenue, Sacramento, California. The copy of the report is for the hospital record. The form is designated primarily for children being removed for purposes of adoption planning, subsequent adoption, or foster care.

b. Parent's Authorization. Prior to the release of a child to non-related persons, the Parent's Authorization Section should be completed in full and the mother or an authorized person having legal custody of the child must sign the authorization which shall designate by name the person(s) to whom the child is to be released, including the purpose for release.

(1) The mother who is a minor may sign Section I - Parent's Signature Authorization. The co-signature of an adult is not required. If the mother wishes to have her parents or her husband co-sign with her, she may do so.

(2) The name of the person(s) authorized to remove the child from the hospital is to be typed or written in the authorization section before the mother signs; otherwise, she would not be designating the person(s) to whom the hospital is authorized to release the child.

c. If the mother does not know and refuses to read the names of the prospective adoptive parents, she may cover the names on the parent form herself. Under no circumstances should a hospital employee cover the names on parent form for the mother. The witness may be a hospital employee. It is not necessary to have the form signed before a notary public.

d. When a mother's signature on the Infant Release cannot be obtained because of her death and release of the infant is sought by a person who is neither a relative, nor an adoption agency holding a valid relinquishment, nor entitled to custody and release of the infant on any other basis, the person seeking release of the infant must be informed that the order of a competent court will be necessary before the infant can be released. The hospital staff may advise such persons that such an order custody may be obtained from the Juvenile Court through the Probate Department of the Superior Court in a guardianship proceeding.

e. Acknowledgement by Person(s) Receiving Child. This Section is to be signed by the person(s) receiving the child. Space is allowed for more than one signature if more than one person receives the child. At least one of these names must coincide with the name of the person <u>designated</u> by the mother in the Parent's Authorization Section. The witness may be a

hospital employee, not necessarily a notary public. Space is provided for identification of person(s) receiving custody of the child; acceptable identification includes driver's license number, social security number, or some other document which identifies the person(s) to the satisfaction of the hospital.

f. Report of Hospital. This Section specifies items of information all of which should be completed. The Infant Release Report is signed by the administrator or the administrator's designated representative. If a designate representative signs the report, his position title should be stated.

CHAPTER 14

PERIODIC PHYSICAL EXAMINATIONS OF PERSONNEL ON THE TEMPORARY DISABILITY RETIRED LIST (TDRL)

14-1. Purpose. To provide information and assign responsibility for the review of periodic physical examinations of personnel on the Temporary Disability Retired List (TDRL).

14-2. Background. A member who has been placed on the TDRL is required to have an examination periodically to determine if there has been a change in the disability for which they were temporarily retired. Reference (y) requires that the periodic evaluation be conducted with the same scrupulous care and thoroughness as an examination conducted for a medical board. Many members on the TDRL must obtain a leave of absence from their place of employment to report for the periodic examination and every effort shall be made to complete the examination in one day or on an outpatient basis. Reference (y) authorizes admission of members to the sick list (inpatient care) for up to ten days for the completion of the examination. The length of inpatient observation may be extended upon completion of the examination and upon authorization from the Commandant of the Marine Corps (CMC) or the Chief, Bureau of Naval Personnel (BUPERS), as appropriate. It is particularly important that admission as an inpatient be effected for proper evaluation of neuro-psychiatric cases.

14-3. Action

a. Head, Patient Administration Department upon receipt of orders for a member to appear for a periodic physical examination shall:

(1) Forward the member's medical records to the appropriate department for review, designation of a primary examiner, and scheduling. After scheduling, the medical records shall be returned to Patient Administration for the preparation of the appropriate requests for laboratory and radiology studies. If the member's records are not received with the orders, they shall be requested from the Central Physical Evaluation Board.

(2) Notify the member of the scheduled outpatient examination or admission date, as appropriate. Also, arrange for the required consultations, laboratory, and radiology studies.

(a) If the examination cannot be conducted in the month specified in the orders, the member shall be expeditiously advised and given the earliest available date.

(b) If the member cannot be located at the stated address, BUPERS or CMC shall be notified.

(3) Endorse the member's orders upon reporting for the examination and provide assistance in completing all phases of the examination.

(4) Ensure that the primary examiner's report is submitted in the format prescribed by reference (r) within 30 calendar days of the examination. The Director for Administration shall be notified of any delays beyond this 30 day deadline.

(5) Upon receipt of the examination report, complete all required reports and forward it with all medical records to the Central Physical Examination Board, Arlington, Virginia.

(a) In tuberculosis cases, the report shall be forwarded within 15 days after the cultures are read.

(b) In cases involving a member who was found to be mentally incompetent at the time of retirement, or becomes so subsequent to retirement, or whose competence is presently questionable, a medical board shall be convened in accordance with reference (y). A signed copy of the board shall be forwarded to the Navy Appellate Review Activity.

(6) Forward a copy of the examination report directly to the member, unless competent medical authority determines that it would adversely affect the mental or physical health of the member.

b. The Primary Examiner shall:

(1) Review the original medical records prior to scheduling the examination and then return them to the Patient Administration Department, indicating which laboratory and radiology studies will be required.

(2) Determine if admission of the member will be required to complete their evaluation.

(3) Conduct the examination, consisting of the following two parts:

(a) A general physical examination, including a clinical evaluation of the member's current medical condition, as well as all medical and dental complaints since the last periodic physical examination. These findings shall be reported on the Report of Medical Examination (SF-88) and shall include a narrative of description of any abnormal findings.

(b) Periodic physical examination to determine whether any changes have occurred in the member's disabilities since the last periodic examination. This examination shall include the following:

1 An evaluation and history of any disabilities which have been incurred since the member was placed on TDRL.

2 An accurate interval history, presenting a summary of all pertinent data concerning each complaint, symptom, disease, injury, or disability presented by the member which may, or is alleged to, cause impairment to their health. List hospital visits since last TDRL exam.

3 List the member's social history, including marital status, size of family, educational activities, leisure activities, etc.

4 Provide member's recent employment history, income from work, Navy and Veteran's Administration disability percentage, and dollars.

5 Any current therapy.

6 Results of all clinical evaluations and laboratory studies.

7 Accurate history since last examination with reference to member's employment and time lost due to the disability for which retired.

8 A prognosis statement by the examiner to include comments concerning present stability and the likelihood of any significant change.

(c) In conducting this examination, it should be noted that:

1 The time period that the member has been on the TDRL is not considered active duty.

2 All prior medical records and physical evaluation board proceedings available to the examiner are also available to those who must subsequently review the report. Therefore, in most cases it is unnecessary to reiterate the content of these records as part of the recurrent report of examination.

3 Diagnostic laboratory and radiological procedures will be employed only to the extent necessary to accurately establish the member's current physical status.

4 When applicable, sedimentation rate, bacteriological and other appropriate laboratory studies will be included with a statement as to the degree of activity or inactivity of tuberculosis.

(d) Prepare a report of the periodic physical examination within 15 calendar days utilizing the format prescribed in reference (y), and forward it to the Patient Administration Department via the appropriate department head for review.

CHAPTER 15

STAFF HOSPITALIZATION FOR ELECTIVE SURGERY

15-1. Purpose. To establish and promulgate policy for admission to the sicklist for elective surgery in the case of military staff personnel.

15-2. Background. In the past, medical officers have, on occasion, hospitalized military staff members for elective surgery without knowledge or consent of their Department Head, or Manpower Management Department. Such unanticipated losses frequently create a hardship on the remaining members of the staff, and may curtail the productivity of a key area. If such elective surgeries are adequately planned, there is less impact on other personnel and on productivity.

15-3. Action

a. Appendix O will be completed by the medical officer contemplating hospitalization of a staff military member for elective surgery involving a period of hospitalization (including Same Day Surgery) or convalescent leave.

b. The request will be forwarded the Executive Officer via the member's Department Head; Director; and Head, Manpower Management for a final decision.

c. (No elective surgery requiring hospitalization will be accomplished without an approved request.) Requests are to be submitted no less than three (3) weeks in advance. Department Heads will adhere strictly to this policy.

CHAPTER 16

MEDICAL EVACUATION PROCEDURES

16-1. Purpose. To establish procedures for the medical evacuation, by both air and ground transportation of seriously ill or injured patients.

16-2. Policy. This command receives patients requiring medical treatment from other medical treatment facilities, civilian authorities and operational exercises. Any patient requiring specialized care beyond the capabilities of this hospital shall be transferred as expeditiously as possible to the appropriate medical treatment facility. Authority to order a patient transfer and the mode of transportation rests solely with the attending physician.

16-3. Action. For all medevacs, air or ground:

a. During normal working hours the Head, Patient Administration shall coordinate ground transportation and completion of the following forms, as appropriate:

(1) Referral for Civilian Care, DD-2161. This form is required for patients sent to a civilian healthcare facility for diagnostic tests, if admission to the facility is not expected.

(2) Disengagement for Civilian Medical Care, NAVMED 6320/30 shall be completed for CHAMPUS eligible patients referred to a civilian medical facility for services not available at this facility.

(3) All patients that are transferred to another facility will have the Patient Transfer Form (Appendix P) completed.

b. The transferring physician shall ensure that the receiving medical facility is contacted with an estimated time of arrival as soon as the transportation departs Naval Hospital, Twentynine Palms, California.

c. After normal working hours or in the absence of the Patient Administration Officer, the Officer of the Day shall coordinate ground or air transportation and ensure (Appendix P) is appropriately completed.

d. The attending physician shall:

(1) Contact the receiving hospital to establish an accepting physician. Pertinent information shall also be relayed to the receiving medical facility.

(2) Dictate the narrative summary for patients transferring from an in-patient status or complete the Emergency Treatment Record for Outpatient or Emergency Room patients.

(3) When the patient's status requires it, arrange for the transport physician to accompany the patient.

(4) Determine appropriate equipment to accompany the patient.

16-4. Armed Services Medical Regulating Organization (ASMRO). In accordance with reference (z), patients can be regulated INCONUS to another medical treatment facility using ASMRO.

a. Head, Patient Administration shall:

(1) Ensure that patient information is correct and accurate in order to regulate patients to the correct treatment facilities.

(2) Ensure patients are eligible for ASMRO regulation.

(3) Ensure that the patient's transportation is coordinated to and from the Aeromedical Evacuation site.

b. The attending physician shall:

(1) Complete the SF 513 and the DD Form 602 (treatment section).

(2) Complete a Narrative Summary.

(3) Find an accepting Medical Officer and service and coordinate an appointment time and date.

APPENDIX A

INPATIENT CHECKOUT GUIDE

	Active Duty	Retired Officer	Retired Enlisted	All Dependents	Initials
1. Ward*	X	X	X	X	_____
2. Marine Liaison	X				_____
3. OOD's Desk*	X	X	X	X	_____
4. Collection Agent	X	X		X	_____
5. Admissions*	X	X	X	X	_____
6. Pharmacy*	-------Only if Applicable---------				_____
7. Appoint. Desk	-------Only if Applicable---------				_____
8. Birth Cert. (Patient Admin.)	------Only if Applicable---------				_____
9. Patient Admin. Office	Only if valuables or baggage were deposited				_____

* Denotes areas open after normal working hours.

Ward Verification Upon Return of Checkout Sheet to Ward:

_____ _____

Signature/Printed Name of Ward Personnel Receiving Completed Form

Date

NAVHOSP29PALMS Form 6150/35
(Rev. 2/94)

APPENDIX B

REPORT OF INPATIENT DISPOSITION (ACTIVE DUTY)

NAME: RANK:

SSN:

UNIT:

DATE AND TIME ADMITTED:

DATE AND TIME DISCHARGED:

PATIENT IS DISCHARGED TO THE FOLLOWING CONDITION:

( ) FULL DUTY

( ) CONVALESCENT LEAVE RECOMMENDED FOR A PERIOD OF _____ DAY(S)

( ) LIGHT DUTY FOR A PERIOD OF _____ DAY(S), TO EXPIRE _____.

( ) NO PFT FOR A PERIOD OF _____ DAY(S), TO EXPIRE

( ) OTHER, EXPLAIN:

_____ _____
PHYSICIAN'S SIGNATURE/STAMP DATE SIGNED

NAVHOSP29PALMS Form 6320/70
(Rev. 2/94)

STATEMENT OF REFUSAL OF TREATMENT AGAINST MEDICAL ADVICE

This is to certify that I, _____, a patient in Naval Hospital, Twentynine Palms, CA, am refusing the advice of the attending physician. _____, And hospital administration. I acknowledge that I have been informed on the risk involved and hereby release the attending physicians and the hospital from all responsibility and adverse effect which may result from this action.

As a active duty member of the United States Department of Defense, I understand that if I refuse reasonable medical or surgical treatment, and my ability to perform full duty is suspect, a medical board may be initiated which might result in my discharge without benefits.

Specific recommended treatment which has been refused:

_____

_____

Specific risks assumed by the patient:

_____

_____

Physician: _____ _____
Patient's Signature

Witness: _____ _____

Date: _____ Guardian or Relative's Signature

Time: _____ _____
Relationship

Reminder to Providers:

1. Active duty personnel are eligible to sing out AMA. In an Active duty patient leaves AMA, the Head, Patient Administration (OOD after hours) must be notified immediately.

2. Physicians must document AMA in the progress note of inpatient and outpatient record/emergency treatment record (ETR) of outpatient.

Distribution: Medical Director (Original)
Patient Administration (Copy)
OOD's Desk (Copy)
Patient's Chart (Copy)
Performance Improvement (Copy)

NH29PALMS FORM 6320/71 (6-95)

Appendix C
to Enclosure (l)

APPENDIX D

INPATIENT RECORD FORMS

A BLACK INDELIBLE PEN SHOULD BE USED TO RECORD ALL PATIENT DATA

All discharge records will be picked up from the ward between 0600-0800 by Medical Record Personnel the first working day after the patient has been discharged from the hospital. Each page must have proper and LEGIBLE patient identification in the lower left hand corner.

Inpatient Admission/Disposition Record. All final diagnoses for which patient was treated or observed must be listed. Abbreviations are NOT allowed. All surgery procedures performed are to be listed under surgery procedures, (item 44). This form must be completed before the patient is discharged. Also, the physician shall indicate the disposition of the patient. If convalescent leave is recommended, indicate number of days recommended.

SF-502 Narrative Summary (Clinical Resume). Summarizes pertinent inpatient (clinical) data relative to treatment received during periods of hospitalization. The original (typewritten) SF-502 shall be filed in the inpatient (clinical) treatment record and a copy in the outpatient record or to Sick Call as appropriate.

SF-504, SF-505, and SF-506 History Parts 1, 2, and 3 and Physical Examination. A "long form" must be completed on all patients admitted for other than "minor" conditions. Admissions with an anticipated length of stay greater than 72 hours require this "long form" admission document.

SF-508 Doctors Orders. Each order will be signed by the person transcribing orders. Immediately after the last word of the order, the person transcribing should sign full name, rank, date and time. If orders are transcribed by a hospital corpsman or ward secretary, a registered nurse (RN) must co-sign. There must ALWAYS be an admitting and discharge order. All nurse midwife orders must be co-signed by a staff physician. All nurse anesthetist orders must be co-signed by a staff physician.

SF-509 Progress Notes. A minimum of one progress note per day for any patient, including patients subsisting at home, must be written. All progress notes must be dated and timed. There must be an admission and discharge progress note written, except for hospital stays of less than 72 hours when the discharge progress note can be completed on the SF-539. OB patients must have a delivery progress note documented on the SF-509. Each patient

undergoing surgery with other than local or topical anesthesia, shall have at least one pre-anesthesia note by either a physician or nurse anesthetist, and at least one post-anesthesia note describing the presence or absence of anesthesia related complications after the patient has been released from the Recovery Room.

SF-510 Nursing Notes. All nursing notes require a date and time. Date may be omitted only if several entries are made in a 24 hour period. Time is required for every entry. All entries must be signed. If the entry is continued to a new page, the first page of the entry should have a complete signature. A RN will review and sign corpsman's entries after each shift, and a RN must review and sign the last entry before the discharge nursing notes, and review and sign the discharge nursing notes.

SF-513 Consultation. Consultations imply an examination of the patient and the patient's record. The consultation note should be recorded and either signed or authenticated by the consultant. The request portion of the consult should be completed and signed by the requesting physician. Following the consultation, the requesting physician should initial to indicate he has read the report.

SF-515 Operation Report. All Operation Reports shall be dictated immediately after surgery. A dictated Operation Report is required on all patients taken into the Main Operating Room (OR). This applies to non-surgical procedures and canceled cases as well. Should a case have to be canceled at any point after the patient is taken into the OR, the dictated report must include the reason(s) for cancellation. Cases classified as "Minor" which are performed in a minor operating room also require a dictated Operation Report.

SF-517 Anesthesia. The anesthesia record must be completed in full and signed by the anesthesiologist or nurse anesthetist on the back and co-signed by the surgeon.

SF-518 Blood or Blood Component Transfusions. Even if there are no adverse reactions, blood transfusions must be mentioned in the progress notes and on the narrative summary.

SF-519 Radiology Reports. There is no requirement for a routine chest x-ray on admission. However, x-ray chits shall be initialed by the doctor to document acknowledgement of the report.

SF-519A Backing Sheet for Mounting Radiology Reports. When completed in conjunction with inpatient care, attach to SF-519 in chronological order with the most recent report on top of each previous report

SF-520 Electrocardiograph Record. When completed in conjunction with inpatient care, include baseline and all subsequent electrocardiographs (EKG). Each report must have an impression documented and initialed by the physician who interpreted the EKG.

SF-522 Operation/Procedures Consent Form. Each form should be completed, signed and witnessed. If consent is in chart, and procedure is not performed, doctor should write "surgery/procedure canceled" on form.

SF-533 Prenatal and Pregnancy. When completed in conjunction with inpatient care, the original of the SF-533 shall be filed in the Inpatient Record, and a copy shall be filed in the outpatient medical treatment record.

SF-535 Newborn Clinical Record. In infant's chart the Newborn Clinical Record, delivery section, should be completed (all blocks) and signed by the obstetrician. Type of delivery should not be abbreviated. The initial physical examination should be completed within 24 hours, with all blocks completed and with the attending physician's signature and date. The back of the Newborn Record should be completed upon discharge of the infant, with all areas completed, including the signature of examining physician, date of discharge, and infant's discharge weight. The progress section should contain at least a discharge progress note. If a circumcision is performed, there should be a progress entry stating so. Each progress note should have a date and time notated and a signature.

SF-539 Abbreviated Medical Record. Admissions routinely expected to be 72 hours or less and of a minor nature, the Abbreviated Medical Record (SF-539) may be used. ALL ENTRIES SHALL BE LEGIBLY WRITTEN. The History and Physical Examination must be documented on the SF-539. In the event that additional space is needed for progress notes, the SF-509 (Doctor's Progress Notes) may be used. However, the discharge progress note must be on the front of the SF-539. This note shall include all discharge diagnoses and procedures (without abbreviations), discharge date and time, with dates of procedures done, condition on discharge, medications, follow-up plan and activity instructions. It shall be signed by the attending physician, and countersigned as required. If the patient's hospitalization is expected to be longer than 72 hours, the SF-539 must be expanded to a long form, and the doctor MUST

complete History Part 1 (SF-504), History Part 2 and 3 (SF-505) and Physical Examination (SF-506). The attending physician must, upon discharge of the patient, dictate a narrative summary which is then typed by a transcriptionist. Narrative summaries are required on all patients hospitalized longer than 72 hours and all deaths.

SF-546 through 557 Laboratory Reports. When completed in conjunction with inpatient care, attach to SF-545 in chronological order with the most recent on top. All lab chits must be initialed by the attending physician to notate that the results have been reviewed.

SF-558 Emergent Care and Treatment. Should be included in chart when the patient is admitted through the Emergency Room. All areas should be completed and signed by the physician who treated the patient. The original copy goes into the inpatient record.

DD-2005 Privacy Act Statement. Patient must read, sign, and give Social Security Number and date.

NAVMED 6320/11 Newborn Identification Sheet. The person taking the footprints WILL NOT be the same person who confirms completion of identifying procedures. All blocks must be completed and the newborn ID tag attached. In case of transfer the senior member on the transport team shall sign the "PERSON TAKING CUSTODY" block.

NAVMED 6320/16 Recovery Room Record. Should be completed with operation performed, agent and techniques of anesthesia, post-anesthesia, recovery score, remarks, if applicable, and signature of admitting nurse or anesthetist for all surgical patients.

NAVMED 6550/8 Medication Administration Record. Should record all medications given, date and hour given, initials of person administering medications, and full signature and title of person administering medications in signature block. If for some reason a medication is not given at the time ordered the block should not be left blank, it should be marked as "NOT GIVEN".

NAVMED 6550/12 Patient Profile. Used to provide ready reference data in caring for a specific patient. Start Patient Profile at time of admission, and update throughout hospitalization.

NAVMED 6550/13 Patient Care Plan. To provide a format for establishing discharge objectives, referral activities, problems, expected outcomes, reevaluation dates, and nursing actions or orders. Start Patient Care Plan upon admission. It is a permanent part of the clinical record and must be written in ink.

RN should sign at end of Discharge Objectives and at end of Actions/Orders. This must be included in ALL patients' charts when admission exceeds 48 hours. In the case of a same day surgery, the NH29P 6010/30 Patient Care Plan will suffice.

NAVMED 6550/14 Patient Data Base. To summarize a patient's health history that will identify actual or potential problems. During admission procedure, explain purpose of Patient Data Base to patient. The patient should fill out Section I using black ink. Nurse reviews Section I, interviews patient to clarify information, and records findings in Section II and signs Section II. Using information from Patient Data Base, nurse starts Patient Care Plan and completes appropriate sections of Patient Profile. This must be completed for all patients.

NH29P 6010/30 Preoperative Teaching Sheet/Peri-operative Patient Care Plan. To be completed on all surgical patients. Full signature is required on the front and back.

NH29P 6150/21 Record Discrepancy Form. This form is used by the Inpatient Records office to notate discrepancies found in the chart. It is to be written on only by the Medical Records Technicians completing and signing the form.

NH29P 6150/31 Transition Newborn Summary. This form will be used for the first four hours of life. During this transition period this form will provide the following: Pertinent labor and delivery information, neonates vital signs, measurements, DXT stix protocol, and nursing notes for physical assessment. All nursing note entries must be timed and signed. Entries by Hospital Corps personnel must be reviewed and countersigned by a nurse.

NH29P 6150/32 24-Hour Nursery Flow Sheet. This form will be started when the neonate is four hours old and continue with a new flow sheet every 24 hours until discharge. Signature blocks at the end of each eight hour shift must be completed. Nursing note entries must be timed and initialed, with initials and corresponding signatures provided in the appropriate block on the form.

NH29P 6150/33 Newborn Maturity Rating and Classification. Form must be completed in full (front and back) and signed by the person completing the form.

NH29P 6300/4 Labor Room Flow Sheet. Should contain admission nursing notes, date and vital signs as determined by protocol. Entries should be initialed, and initials and full signature should appear at bottom of page in signature block.

NH29P 6550/10 IV Flow Sheet. Each entry will be filled out entirely, including initials of person completing each entry. When the IV is changed to a Heplock, as well as discontinued, this will be notated on the IV flowsheet. Each person who makes an entry on the IV Flow Sheet will initial, sign and notate title in the signature block at the bottom of the page.

APPENDIX E

MEDICAL STAFF GUIDELINES FOR SIQ AND CONVALESCENT LEAVE

GENERAL GUIDELINES: The length of time recommended for convalescent leave or SIQ status should be kept to a minimum, particularly in the case of illnesses that may require frequent re-evaluation. When placed on convalescent leave, a member is free to travel anywhere while on leave, and may not be available for re-evaluation; however a patient may placed sick in quarters must remain in the geographical location. Patients may not be discharged from the hospital to a sick in quarters status.

DIAGNOSIS	RECOMMENDED SIQ/CONLEAVE
Ankle injury/fx	2 - 5 days*/N/A
Appendicitis	N/A /2 - 4 weeks
Arthroscopy	N/A /2 - 4 weeks
Back pain	3 - 7 days*/1 week*
Cellulitis, feet	2 - 4 days/1 week
Chickenpox	1 - 2 days**/1 week**
Heat exhaustion	1 - 2 days/1 week
Heat stroke	N/A /Medical board
Hernia repair	N/A /2 - 4 weeks
Hepatitis	3 - 7 days*/2 - 4 weeks
Knee injury, acute	2 - 3 days/ N/A
Migraine headache	24 hours/ N/A
Mononucleosis	3 - 7 days*/ 2 - 3 weeks
Problem pregnancy	7 days*/ 7 days
Pregnancy delivered	N/A /42 days
Renal stone	2 - 4 days/ 1 - 7 days

* May be extended after follow-up visits
** Chickenpox may not be returned to barracks or household without attendant

APPENDIX F

MEDICAL DUTY REVISED STATUS FORM

Date _____

From:
To: Commanding Officer,

Subj: DUTY STATUS OF _____ SSN

1. Subject has been placed on sick in quarters for a period of
days. Restrictions of this duty status are as follows:

__ a. No duty, confined to bed except for mess facilities.
__ b. No duty, confined to quarters except for mess facilities.
__ c. No duty, to rest at home where nursing care is
available. Not to exceed _____.
__ d. Light duty, no marching, prolonged standing, or field work.
__ e. Limited use of extremity. _____.
__ f. Special clothing recommendation. _____.
__ g. No mess duty.
__ h. No rifle range duty in _____ position.
__ i. No shaving for _____ days. (Navy only, see MCO 1700)
__ j. Return to this dispensary __ times a day.
__ k. Other
_____

__ l. Liberty is/is not considered detrimental. Diagnosis
_____. (Full benefit of the medical treatment cannot be guaranteed unless this stipulation is enforced.)

2. It is recommended that the member identified above be placed on convalescent leave for a period of _____ days.

3. If the patient voluntarily violates the above indicated stipulation(s), this chit is automatically void and the patient is to be considered fit for full duty; and the patient may be processed for disobedience of a direct order.

4. The patient **must return to sick call at ___ on ____.** This duty status will expire at **___ on _____.**
This chit must be submitted to the patient's parent command on the same day that it is issued.

_____
Medical Officer's Signature/stamp

I understand the provisions and restriction of this medical duty revised status recommendation.

_____
Patient's Signature

NAVHOSP29PALMS Form 6320/04
(Rev. 2/94)

APPENDIX G

LEGAL CONSENT REQUIREMENTS FOR MEDICAL TREATMENT OF ADULTS AND MINORS

PATIENT	WHO HAS TO CONSENT
Adult	Himself/Herself
Adult mentally competent but physically unable to sign a consent form	Himself/Herself
Adult mentally competent but unable to speak or write	Himself/Herself
Married adult abortion or sterilization; see SECNAVINST 6300.2)	Himself/Herself (spouse if it is an
Incompetent adult patient under guardianship or conservatorship	Court appointed legal guardian or conservator.
Incompetent adult patient, not under guardianship or conservatorship	Court appointed legal guardian or conservator. (Also spouse, adult child and patient's brother or sister;
Adult with certain religious faiths	Himself/Herself or requires civilian court order in the case of a pregnant mother.
Minor	Natural parent, a legal guardian or court appointed guardian.
Minor with divorced parents	Natural parent or legal guardian having custody. Refer to court decree

Adopted minor	Legal guardian, or legally adopted parent
Minor placed for adoption	Adoption agency if they have a relinquishment from the parent or natural parent
Minor born out of wedlock	Natural mother, or natural father if he had legitimized the child
Children of minor parent	Natural parent
Minor pupil	Hospital physician may provide reasonable treatment to any child enrolled in any school in any district when the child is ill or injured during regular school hours.
Non-abandoned minor whose parents are unavailable	Try to contact natural parents or third person authorization to consent
Abandoned minor	Court order; see enclosure (2) of this instruction
Minor in the custody of foster parents	Legal guardian or natural parent
Minor of a religious faith.	Natural parent or court order; see enclosure (2) of this instruction.
Minor living away from home (emancipated minor)	Himself/Herself

Minor on active duty with U.S. Armed Forces	Himself/Herself
Minor receiving pregnancy care or abortion	Natural parent, guardian, or court order
Minor suffering from a reportable disease	Himself/Herself, if over 12 years of age
Minor as victim of rape or sexual assault	Himself/Herself
Minor with drug or alcohol related problems	Himself/Herself, if over 12 years of age
Married minor	Himself/Herself (spouse also if it is an abortion or sterilization; see SECNAVINST 6300.2)
Minor under court jurisdiction, e.g., awaiting disposition at Casa de Amparo	Court appointed guardian

APPENDIX H

SAMPLE PHYSICIAN'S VERIFICATION OF PERMISSION TO TREAT A MINOR

Date_____

Social Services Department
County of San Bernardino
57098 29 Palms Hwy
Yucca Valley, CA 92284

_____, _____, has been examined by
(Name of minor) (Age)
me because of an illness or injury, to wit: _____

_____

_____

In my opinion as attending physician, the minor requires immediate emergency medical treatment, which may include surgery, transfusion of blood, and/or other accepted medical procedures,

specifically _____

_____

_____

As attending physician, it is my opinion that if the above medical treatment is not performed, the following effects could

result: _____

_____

_____

The minor's parent(s) objects to this treatment: _____ Yes _____ No

The minor's parent(s) is/are available: _____ Yes _____ No

_____
(Signature and Rank)
Naval Hospital, Twentynine Palms, CA

APPENDIX I

EMANCIPATED MINOR INFORMATION

For the purposes of obtaining diagnosis or treatment at the Naval Hospital, Twentynine Palms, or by any physician, surgeon, or dentist associated with it, the undersigned certifies the following facts are true:

1. I am living separate and apart from my parents or legal guardian.

_____
Place of residence Phone

_____
Place of residence of parents Phone

2. I am managing my own financial affairs regardless of source of income (so long as it is not derived from a source declared to be a crime by law).

_____
Bank and account number

_____
Place of employment or other source of financial support

3. I understand that I will be financially responsible for the charges for my medical or hospital diagnosis, treatment and care and that I may not disaffirm this consent because I am a minor. I am _____ years of age, having been born on the _____ day of _____, 19 _____.

Dated_____

Signed_____

Witness_____

Witness_____

APPENDIX J

AUTHORIZATION TO CONSENT TO MEDICAL CARE
SPECIAL POWER OF ATTORNEY

That I, _____,
Full name, Status (such as DW/USMC/AD)
_____, _____,
Sponsor's SSN Sponsor's rank/rate
stationed at Marine Corp Air Ground Combat Center, Twentynine Palms, California, and by these presents do make, constitute, and appoint
_____, _____
Full name
Present address
_____, as my true and lawful attorney-in-fact to perform all necessary acts that I might perform if I were present for the following purposes: To procure and authorize any and all medical and hospital care and treatment, including major surgery, deemed necessary by a duly licensed physician in any military or civilian hospital, dispensary, doctor's office, medical facility, or in or at any other place, if such treatment or surgery is recommended to be in the best interest of the health and welfare of my child(ren) as named herein:

Full name	Date of birth	Age	Relationship
_____	_____	_____	_____
_____	_____	_____	_____

It is understood that a valid dependent's ID card must accompany dependents ten years of age or older. When dependent is under ten years of age, please provide:

_____
Sponsor's ID card number and date of expiration

This special power of attorney, unless sooner revoked or terminated by me, shall become null and void on _____.
Day Month Year

_____
Signature of grantor

STATE OF CALIFORNIA
COUNTY OF SAN BERNARDINO
MCAGCC, TWENTYNINE PALMS

On _____, before me, I witnessed the person
Day Month Year
whose name subscribed above, and acknowledged to that he/she executed a free and voluntary act for the purposes herein expressed. The undersigned does further certify that he/she is a commissioned officer and is in the active service of the Armed Forces of the United States.

_____
Signature and rank of witness

NAVHOSP29PALMS Form 6322/41
(Rev. 3/94)

APPENDIX K

DECEDENT AFFAIRS CHECK-OFF LIST

SECTION 1

NAME (LAST-FIRST-FULL MIDDLE) RANK/RATE SOCIAL SECURITY NUMBER

UNIT/HOME ADDRESS POSSIBLE CAUSE OF DEATH TIME & DATE OF DEATH

PLACE OF DEATH LOCATION OF REMAINS PHONE NUMBER

DATE OF BIRTH AGE SEX RACE ETHNICITY RELIGION MARITAL STATUS

SECTION 2

LOCAL NOTIFICATIONS	DATE	TIME	INITIALS
A. COMMANDING OFFICER			
B. EXECUTIVE OFFICER			
C. DIRECTOR FOR ADMINISTRATION			
D. MEMBER'S UNIT			
E. DUTY CHAPLAIN			
F. STAFF (MCAGCC) DUTY OFFICER			
G. CORONER			
H. AMERICAN RED CROSS			

SECTION 3

IDENTIFICATION OF REMAINS: WHEN THE NEXT OF KIN IS NOT PRESENT, IDENTIFICATION OF THE REMAINS IS TO BE MADE BY AN OFFICER FROM THE DECEASED'S COMMAND OR SOMEONE WHO IS PERSONALLY ACQUAINTED WITH THE DECEASED.

_____ _____NAME OF
IDENTIFIER RELATIONSHIP

SECTION 4

ADMINISTRATIVE PROCEDURES	DATE	TIME	INITIALS
A. ACCIDENT/INJURY REPORT			
B. CHRONOLOGICAL RECORD OF MEDICAL CARE			
C. IN CASES WHERE THE DECEASED IS NOT ACTIVE DUTY, THE ATTENDING MEDICAL OFFICER IS TO NOTIFY THE NEXT OF KIN IF PRESENT			
D. AUTHORIZATION FOR DISPOSITION			

APPENDIX L

(Letter Head)

(Patient's Name)
(Home Address)

Dear :

Our records show that on_____ you failed to appear for a medical appointment with_____ of the Naval Hospital or to call more than 60 minutes in advance to cancel the appointment.

The Naval Hospital has very limited medical resources to provide care to a growing Marine Corps Air Ground Combat Center population of active duty personnel and their dependents. With our limited provider staff and appointment schedules, many patients must wait to receive medical appointments. It is the responsibility of patients who are unable to keep appointments to advise hospital personnel at least one hour in advance. Failure to promptly cancel deprives other patients of the opportunity to use that appointment time to receive medical care.

Should you be unable to keep a future appointment, please call 830Ä2342 or 830-2286 at least 60 minutes in advance to cancel or reschedule the appointment. Messages to cancel appointments may be left on recorder by dialing 830-2342. It is our goal to provide the best possible medical care to all our patients and we sincerely appreciate your full cooperation and support in this effort.

Sincerely,

A. M. SWAP
Lieutenant, Medical Service Corps
United States Naval Reserve
Head, Patient Administration Department
By direction of the
Commanding Officer

NAVHOSP29PALMS Form 6300/01
(Rev. 3/94)

APPENDIX M

(Letter Head)

6320
Code 150/

From: Commanding Officer
To: (Sponsor)
Via: (Sponsor's Commanding Officer)

Subj: FAILURE TO APPEAR FOR MEDICAL APPOINTMENT

1. Your dependent,_____, has failed to appear on two medical appointments at the Naval Hospital at on_____ and at_____ on , or failed to call more than 60 minutes in advance to cancel these appointments.

2. The Naval Hospital has very limited medical resources to provide care to a growing Marine Corps Air Ground Combat Center population of active duty personnel, their dependents, and retirees and their dependents. With our limited provider staff and appointment schedules, many patients must wait to receive medical appointments. It is the responsibility of patients who are unable to keep appointments to advise hospital personnel in at least one hour in advance. Failure to promptly cancel deprives other patients of the opportunity to use that appointment time to receive medical care.

3. Should your dependents be unable to keep a future appointment, please have them call 830-2342 or 830-2286 at least 60 minutes in advance to cancel or reschedule the appointment. Messages to cancel appointments may be left on recorder by dialing 830-2342. It is our goal to provide the best possible medical care to all our patients and we sincerely appreciate your full cooperation and support concerning this matter.

A. M. SWAP
By direction

NAVHOSP29PALMS Form 6300/02
(Rev. 3/94)

APPENDIX N

(Letter Head)

6320
Code 150/

From: Commanding Officer
To: (Sponsor's Commanding Officer)

Subj: FAILURE OF PATIENT TO APPEAR FOR MEDICAL APPOINTMENT

1. On_____ at_____, _____,dependents of _____ failed to appear at the Naval Hospital for a scheduled medical appointment. This was not the first failure of the member or his dependent to keep an appointment or to cancel it in advance. Previous correspondence to the member requesting assistance in this regard has not corrected the problem.

2. The Naval Hospital has very limited medical resources to provide care to a growing Marine Corps Air Ground Combat Center population of active duty personnel, their dependents, and retirees and their dependents. With the limited provider staff and appointment schedules, many patients must wait to receive a medical appointment. It is the responsibility of patients to advise hospital personnel in advance (830-2342 or 830-2286) when they will be unable to keep an appointment. Messages to cancel appointments may be left on recorder when dialing 830-2342. Failure to do so deprives other patients the opportunity to use that appointment time to receive medical care.

3. Your assistance is requested in ensuring that the member fulfills his responsibilities by using the appointment system properly. It is our goal to provide the best possible care to all our patients. We sincerely appreciate your support regarding this matter.

C. S. CHITWOOD

APPENDIX O

REQUEST FOR ELECTIVE SURGERY/HOSPITALIZATION

Date:

From: _____
(Requesting Medical Officer/Clinic)

To: Executive Officer
Via: (1) _____
(Department Head)
(2) _____
(Director)
(3) Head, Manpower Management

Subj: ADMISSION FOR ELECTIVE SURGERY/HOSPITALIZATION ICO _____

Ref: (a) NAVHOSP29PALMS 6300.1

1. In accordance with reference (a), it is recommended the subject named member/officer be admitted to the sick list on _____ for _____.
(date) (diagnosis)
2. Estimated length of hospitalization is _____.

3. Estimated length of convalescent leave is _____.

_____
(signature)

_____
Date:

FIRST ENDORSEMENT

From: _____
(Department Head)
To: Executive Officer
Via: _____
(Director)

1. Recommended/Not Recommended.

2. Relief Required/Not Required.

_____
(signature)

NAVHOSP29PALMS Form 6320/07
(Rev. 2/94)

Date:

SECOND ENDORSEMENT

From: _____
(Director)
To: Executive Officer
Via: Head, Manpower Management

1. Recommended/Not Recommended.

_____
(signature)

Date:
THIRD ENDORSEMENT

From: Head, Manpower Management
To: Executive Officer

1. EAOS:_____.

2. PRD: _____.

_____
(signature)

Date:

FOURTH ENDORSEMENT

From: Executive Officer
To:

1. Approved/Disapproved.

_____
(signature)

Copy to:
Dept. Head
Director
Manpower

NAVHOSP29PALMS Form 6320/07
(Rev. 2/94)

PATIENT TRANSFER FORM

PART I
PATIENT INFORMATION: (TO BE FILLED OUT BY TRANSFERRING DEPARTMENT)

PATIENT: _____ SSN: _____/_____
LAST FIRST MI PREFIX (SPONSORS SSN IF DEPENDENT)

RANK/STATUS: _____ UNIT: _____
(UNIT IF ACTIVE DUTY, SPONSORS UNIT IF DEPENDENT, MAILING ADDRESS IF CIV-HUM)

HOME PHONE #: _____ WORK PHONE #: _____

==========

PART II
MEDICAL INFORMATION: (TO BE FILLED OUT BY TRANSFERRING DOCTOR)

MEANS OF TRANSPORT: _____
(MERCY AIR, BEARMAT HELO, AMBULANCE, HOSPITAL VEHICLE, UNIT DUTY VEHICLE)

TRANSPORT PERSONNEL: _____
(TRANSPORT, DOCTOR, NURSE, EMT, AND/OR CORPMAN)

DIAGNOSIS: _____

REASON FOR TRANSFER: _____
(TYPE OF SERVICES, PROCEDURED, OR TESTS NOT AVAILABLE, AT THIS HOSP)

TRANSFERRED TO: _____

ACCEPTING DOCTOR/SERVICE: _____

TRANSFERRED WITH:
(CHECK APPROPRIATE)
___ NARRATIVE SUMMARY
___ INPT RECORD (COPY)
___ OUT PT RECORD (COPY)
___ X-RAYS
___ LAB WORK

TREATMENT RECOMMENDED IN ROUTE: (MEDICATIONS, MONITORS, IV'S AND RATES, IF NONE SO STATE)

_____

DISPOSITION OF PATIENT: _____
(PT TO BE ADMITTED, RETURN, RETURN ONLY IF TESTS NEGATIVE)

PART III
ADMINISTRATION: (TO BE FILLED OUT BY PATIENT ADMINISTRATION OR OOD)

MEANS OF TRANSPORT: **HELO**
_____ TIME HELO REQUESTED
_____ TIME HELO ARRIVED
_____ TIME HELO DEPARTED
_____/_____DATE AND REQUESTED
_____/_____ DATE AND TIME DEPARTED

HOSPITAL VEHICLE _____ (TYPE)
_____/_____ DATE AND TIME REQUESTED
_____/_____ DATE AND TIME DEPARTED

UNIT DUTY VEHICLE ARRANGED WITH:
_____
(UNIT REP) (DATE)

IF ACTIVE DUTY UNIT NOTIFIED: _____/_____
(NAME RANK AND POSITION) (DATE AND TIME)

DISENGAGEMENT FORM COMLETED BY: _____

TRANSFER APPROVED BY: _____/_____
(PATIENT ADMIN OR OOD) (DATE AND TIME)